

STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-2 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to discontinue Tennessee Medicaid/TennCare coverage of adult dental. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. *[This document will be attached when the SPA is submitted to CMS.]* We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1025013

| TRANSMITTAL AND NOTICE OF APPROVAL OF | 1. TRANSMITTAL NUMBER: | 2. STATE |
|---|---|-------------|
| STATE PLAN MATERIAL | 2005-2 | TENNESSEE |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX | OF THE |
| | SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR | 4. PROPOSED EFFECTIVE DATE | |
| HEALTH CARE FINANCING ADMINISTRATION | 4. PROPOSED EFFECTIVE DATE | |
| DEPARTMENT OF HEALTH AND HUMAN SERVICES | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | |
| 3. THE OF TEAN MATERIAL (Check One). | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSIDERED AS | NEW PLAN AMENDMENT | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AM | ENDMENT (Sanarata Transmittal for each amonds | mont) |
| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: | neni) |
| 42 CFR 440 and 441 | a. FFY 2004/2005 \$ | |
| | b. FFY 2005/2006 \$ | 3 |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERSEDED PI | LAN SECTION |
| Attachment 3.1-A, page 4 | OR ATTACHMENT (If Applicable): | |
| Attachment 3.1-B, page 4 | Attachment 3.1-A, page 4; Attachment 3.1.A.1, I | Itam 10: |
| | Attachment 3.1-A, page 4, Attachment 3.1.A.1, I | |
| | ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,, | |
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| | | |
| 10. SUBJECT OF AMENDMENT: Amount Duration and Scope of Medical and Remedia | Care and Services Provided to the | |
| Categorically and Medically Needy; Limitation on Amount, Duration and Scope of Medica | | |
| Dental. | | |
| | | |
| 11. GOVERNOR'S REVIEW (Check One): | | |
| X GOVERNOR'S OFFICE REPORTED NO COMMENT | ☐ OTHER, AS SPECIFIED: | |
| COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | | |
| ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | |
| | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: | |
| | Tennessee Department of Finance and Administr | ation |
| 13. TYPED NAME: J. D. Hickey | Bureau of TennCare 729 Church Street | |
| 13. I II LD IVAIVIL. J. D. HICKCY | Nashville, TN 37247-6501 | |
| 14. TITLE: Deputy Commissioner | 1 | |
| | Attention: George Woods | |
| 15. DATE SUBMITTED: | - | |
| | | |
| FOR REGIONAL (| OFFICE USE ONLY | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | |
| | | |
| PLAN APPROVED – O | NE COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICIAL: | |
| | | |
| 21. TYPED NAME: | 22. TITLE: | |
| 23. REMARKS: | | |
| 20. REMARKO. | | |
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Revision: HCFA-PM-85-3 (BERC) ATTACHMENT 3.1-A

MAY 1985

Page 4

OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

| 9. | Clinic /X / / / | | ces. ided: // provided. | No li | mitations | / X / | With | limitations* |
|-------|------------------------------|---------------------|--------------------------------------|--------------------|--------------|--------------|-------|---|
| 10. | Denta // / X / | Prov | ices. ided: // provided. | No li | mitations | // | With | limitations* |
| 11. | Physic | cal the | erapy and relat | ed ser | vices. | | | |
| | a. | Phys | ical therapy. | | | | | |
| | | / / / X / | Provided: Not provide | / / e d. | No limitatio | ns | // | With limitations* |
| | b. | Occu | ipational thera | py. | | | | |
| | | / / / X / | Provided: Not provide | / / e d. | No limitatio | ns | // | With limitations* |
| | c. | | ices for individ or the supervisi | | <u> </u> | · · | | uage disorders (provided by or ogist). |
| | /X/ | // Not | Provided: provided. | // | No limitatio | ns | // | With limitations* |
| *Desc | cription | provi | ded on attachn | nent. | | | | |
| D107 | 4349 | | | | | | | |
| | o. <u>2005</u> | <u>-2</u> | | | | | | |
| _ | rsedes | ı | Appr | oval D | ate | ПСЕ | | tive Date |
| | o. <u>88-1</u> 1 | <u>l</u> | | | | HCF. | A ID: | 0069P/9992P |

Revision: HCFA-PM-86-20 (BERC)

SEPTEMBER 1986

ATTACHMENT 3.1-B

Page 4

OMB No. 0938-0193

State/Territory: <u>Tennessee</u>

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Children Under 21; Pregnant Women.

| 8. | Private duty nur | sing services. // No limitation | // With limitations* |
|---------------|---|--|--|
| 9. | Clinic services. /X / Provided | // No limitation | / X/ With limitations* |
| 10. | Dental services. // Provided | // No limitation | // With limitations* |
| 11. | a. Physical t // Provide b. Occupation // Provide c. Services for | ed // No limitation on the control of the control o | // With limitations* hearing, and language disorders provided by or under audiologist. |
| 12. | Prescribed drugs skilled in disease a. Prescribed / X/ Provide b. Dentures. // Provide | s of the eye or by an optomed drugs. ded // No limitation | /X / With limitations* |
| * Desc | cription provided o | n attachment. | |
| Super | o. <u>2005-2</u> rsedes o. <u>88-11</u> | Approval Date | Effective Date HCFA ID; 0140/0102A |



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-3 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to point out that methadone clinic services are not provided. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. [This document will be attached when the SPA is submitted to CMS.] We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1035013

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: 2. STATE TENNESSEE | | | | |
|---|--|-------------|--|--|--|
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | | | | |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | | | | |
| TO: REGIONAL ADMINISTRATOR | 4. PROPOSED EFFECTIVE DATE | | | | |
| HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. FROI OSED EFFECTIVE DATE | | | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | | | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSIDERED AS | | | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | | nt) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440 and 441 | 7. FEDERAL BUDGET IMPACT: a. FFY 2004/2005 \$ | | | | |
| 42 CFK 440 and 441 | a. FFY 2004/2005 b. FFY 2005/2006 | | | | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERSEDED PI | LAN SECTION | | | |
| Attachment 3.1-A, page 4; Attachment 3.1-A.1, Item 9; | OR ATTACHMENT (If Applicable): | | | | |
| Attachment 3.1-B, page 4; Attachment 3.1.B.1, Item 9. | Attachment 3.1-A, page 4; Attachment 3.1.A.1 | 1, Item 9; | | | |
| | Attachment 3.1-B, page 4; Attachment 3.1.B.1 | , Item 9. | | | |
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| 10. SUBJECT OF AMENDMENT: | | | | | |
| Amount, Duration and Scope of Medical Remedial Care and Services Provided to Cat | egorically and Medically Needy; Limitation on | | | | |
| Amount, Duration and Scope of Medical Care and Services Provided - Clinic Service | | | | | |
| | | | | | |
| 11. GOVERNOR'S REVIEW (Check One): | | | | | |
| X GOVERNOR'S OFFICE REPORTED NO COMMENT | OTHER, AS SPECIFIED: | | | | |
| ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | | | | |
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| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: | | | | |
| | Tennessee Department of Finance and Admir Bureau of TennCare | nstration | | | |
| 13. TYPED NAME: J. D. Hickey | 729 Church Street | | | | |
| · | Nashville, Tennessee 37247-6501 | | | | |
| 14. TITLE: Deputy Commissioner | Attention: George Woods | | | | |
| 15. DATE SUBMITTED: | _ | | | | |
| | | | | | |
| FOR REGIONAL OF 17. DATE RECEIVED: | FFICE USE ONLY 18. DATE APPROVED: | | | | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | | | | |
| PLAN APPROVED – ON | E COPY ATTACHED | | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICIAL: | | | | |
| 21. TYPED NAME: | 22. TITLE: | | | | |
| 21, 111 LD NAME. | 22. 11166. | | | | |
| 23. REMARKS: | | | | | |
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Revision: HCFA-PM-85-3 (BERC) ATTACHMENT 3.1-A

MAY 1985

Page 4 OMB NO.: 0938-0193

AMOUNT, DURATION AND SCOPE OF MEDICAL AND REMEDIAL CARE AND SERVICES PROVIDED TO THE CATEGORICALLY NEEDY

| 9. | Clinic /X / / / | Provi | | No lii | nitations | / X / | With 1 | limitations* |
|------|------------------------------|---------------------|--------------------------|------------------|-----------------------------------|--------------|--------|--|
| 10. | Denta // / X / | Provi | | No lii | nitations | 11 | With 1 | limitations* |
| 11. | Physic | al the | rapy and relate | ed serv | ices. | | | |
| | a. | Physi | cal therapy. | | | | | |
| | | / / / X / | Provided: Not provide | // d. | No limitation | 18 | // | With limitations* |
| | b. | Occu | pational thera | py. | | | | |
| | | / / / X / | Provided: Not provide | // d. | No limitation | 18 | // | With limitations* |
| | c. | | | | th speech, hear supervision of | · · | _ | nage disorders ologist or audiologist). |
| | | / / / X / | Provided: Not provide | / / d. | No limitation | 18 | // | With limitations* |
| *Des | cription | provid | led on attachm | ient. | | | | |
| D104 | 5013 | | | | | | | |
| | lo. <u>2005-</u> rsedes | 3 | Appre | oval Da | nte | | Effect | ive Date |
| TN N | lo. <u>88-11</u> | _ | | | | HCFA | | 0069P/9 <mark>992P</mark> |

Revision: HCFA-PM-86-20 (B

(BERC)

ATTACHMENT 3.1-B

a

SEPTEMBER 1986

Page 4 OMB No. 0938-0193

State/Territory: <u>Tennessee</u>

AMOUNT, DURATION AND SCOPE OF SERVICES PROVIDED MEDICALLY NEEDY GROUP(S): Children Under 21; Pregnant Women.

| 8. | Private duty nursing // Provided | ng services. // No limitation | // With limitations* |
|---------------|--|---|--|
| 9. | Clinic services. /X / Provided | // No limitation | / X/ With limitations* |
| 10. | Dental services. // Provided | // No limitation | // With limitations* |
| 11. | a. Physical the // Provided b. Occupation // Provided c. Services for provided by // Provided Prescribed drugs, | // No limitation al therapy. // No limitation individuals with speech, h or under supervision of a // No limitation dentures, and prosthetic de diseases of the eye or by a drugs. // No limitation | nearing, and language disorders speech pathologist or audiologist. // With limitations* evices; and eveglasses prescribed by |
| * Desc | cription provided on 5013 | attachment. | |
| Supe | (o. <u>2005-3</u> rsedes (o. <u>88-11</u> | Approval Date | Effective Date HCFA ID; 0140/0102A |
| | | | |

STATE: TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

9. Clinic Services

The following types of clinic services are covered with limitations described for each.

- a. Community Mental Health Centers Services limited to those authorized to be provided.
- b. Community Clinics
 - (1) Community Health Clinics, Community Health Agencies, Community Services Clinics.
 - Services limited to those authorized to be provided by each of the above type clinics.
 - (2) Ambulatory Surgical Centers Services limited to those procedures designated by the state agency that can be performed outside the inpatient facility setting.
 - (3) Community Mental Retardation Clinics Services provided by qualified community Mental Retardation Clinics shall be limited to medically necessary preventive, diagnostic, therapeutic, rehabilitative, or palliative services.
 - (4) Methadone clinic services are not covered.

D1014349

STATE: TENNESSEE

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

9. Clinic Services

The following types of clinic services are covered with limitations described for each.

- a. Community Mental Health Centers Services limited to those authorized to be provided.
- b. Community Clinics
 - (1) Community Health Clinics, Community Health Agencies, Community Services Clinics.
 - Services limited to those authorized to be provided by each of the above type clinics.
 - (2) Ambulatory Surgical Centers Services limited to those procedures designated by the state agency that can be performed outside the inpatient facility setting.
 - (3) Community Mental Retardation Clinics Services provided by qualified community Mental Retardation Clinics shall be limited to medically necessary preventive, diagnostic, therapeutic, rehabilitative, or palliative services.
 - (4) Methadone clinic services are not covered.

D1065013



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-4 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to discontinue Tennessee Medicaid/TennCare coverage of payment made to reserve a bed during a recipient's temporary absence from a nursing facility. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. *[This document will be attached when the SPA is submitted to CMS.]* We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1075013

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: 2005-4 | 2. STATE TENNESSEE | | | |
|--|---|-----------------------|--|--|--|
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | | | | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE | | | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | 1 | | | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSID | ERED AS NEW PLAN AMEN | NDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | NDMENT (Separate Transmittal for each amo | endment) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 447.40 | 7. FEDERAL BUDGET IMPACT: a. FFY 2004/2005 b. FFY 2005/2006 | \$ \$ | | | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 4.19 C. | 9. PAGE NUMBER OF THE SUPERSEDI OR ATTACHMENT (If Applicable): Attachment 4.19 C. | ED PLAN SECTION | | | |
| 10. SUBJECT OF AMENDMENT: Methods of Reimbursing for Reserved Bed Care Facilities for the Mentally Retarded. | s in Nursing Facilities and Intermediate | | | | |
| 11. GOVERNOR'S REVIEW (Check One): X GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | ☐ OTHER, AS SPECIFIED: | | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: | | | | |
| | Tennessee Department of Finance and A Bureau of TennCare | Administration | | | |
| 13. TYPED NAME: J. D. Hickey | 729 Church Street | | | | |
| 14. TITLE: Deputy Commissioner | Nashville, Tennessee 37247-6501 Attention: George Woods | | | | |
| | | | | | |
| 15. DATE SUBMITTED: | | | | | |
| FOR REGIONAL OF | FFICE USE ONLY | | | | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | | | | |
| PLAN APPROVED – ON | E COPY ATTACHED | | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICE | IAL: | | | |
| 21. TYPED NAME: | 22. TITLE: | | | | |
| 23. REMARKS: | | | | | |
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STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE TENNESSEE

METHODS OF REIMBURSING FOR RESERVED BEDS IN NURSING FACILITIES AND INTERMEDIATE CARE FACILITIES FOR THE MENTALLY RETARDED

- a. Medicaid does not reimburse for reserving a nursing facility bed. Nursing facility costs for reserving beds are not medical costs.
- b. Reimbursement for reserved beds in an Intermediate Care Facility for the Mentally Retarded, (ICF/MR) is as follows:
 - (1) For days not to exceed 15 days per occasion while the recipient is hospitalized and the following conditions are met:
 - (a) The resident intends to return to the ICF/MR.
 - (b) The hospital provides a discharge plan for the resident.
 - (c) At least 85% of all other beds in the ICF/MR certified at the recipient's designated level of care (i.e. intensive training, high personal care or medical), when computed separately, are occupied at the time of the hospital admission.
 - (d) Each period of hospitalization must be physician ordered and so documented in the patient's medical record in the ICF/MR.
 - (2) For days not to exceed 36 days per fiscal year while the recipient, pursuant to a physician's order, is absent from the facility on a therapeutic home visit or other therapeutic absence.

D1085013

| TN No. 2005-4 | | |
|---------------------|---------------|----------------|
| Supersedes | Approval Date | Effective Date |
| TN. No. <u>93-5</u> | | |



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-5 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This Plan Amendment points out that the only Optional Medically Needy Groups covered under the State plan are pregnant women and children. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. *[This document will be attached when the SPA is submitted to CMS.]* We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1095013

| TRANSMITTAL AND NOTICE OF APPROVAL OF | 1. TRANSMITTAL NUMBER: | 2. STATE | | | |
|--|--|-----------------|--|--|--|
| STATE PLAN MATERIAL | 2005-5 | TENNESSEE | | | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | | | | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE | | | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | 1 | | | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSID | ERED AS NEW PLAN AMEN | NDMENT | | | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | | endment) | | | |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 435 | 7. FEDERAL BUDGET IMPACT: a. FFY 2004/2005 b. FFY 2005/2006 | \$ \$ | | | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 2.2-A, pages 24 and 26. | 9. PAGE NUMBER OF THE SUPERSED OR ATTACHMENT (If Applicable): Attachment 2.2-A, pages 24 and 26. | ED PLAN SECTION | | | |
| 10. SUBJECT OF AMENDMENT: Groups Covered and Agencies Responsible for Eligibility Determination - O | ptional Coverage of the Medically Needy. | | | | |
| 11. GOVERNOR'S REVIEW (Check One): X GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | ☐ OTHER, AS SPECIFIED: | | | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: Tennessee Department of Finance and Bureau of TennCare | Administration | | | |
| 13. TYPED NAME: J. D. Hickey | 729 Church Street Nashville, Tennessee 37247-6501 | | | | |
| 14. TITLE: Deputy Commissioner | Attention: George Woods | | | | |
| 15. DATE SUBMITTED: | Attention. George woods | | | | |
| FOR REGIONAL OF | FFICE USE ONLY | | | | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | | | | |
| PLAN APPROVED – ON | E COPY ATTACHED | | | | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICE | IAL: | | | |
| 21. TYPED NAME: | 22. TITLE: | | | | |
| 23. REMARKS: | | | | | |
| | | | | | |

Revision: HCFA-PM-91-4 (BPD) 1991

ATTACHMENT 2.2-A

Page 24 OMB No: 0938-

| | S | tate <u>:</u> | Tennessee | | |
|--|------------|---------------|---|--|--|
| Agency* | Citations | s(s) | | Gro | oups Covered |
| | С | ;. <u>(</u> | Optional Coverage o | of the Medica | illy Needy |
| 42 CFR 435. | .301 | ٦ | Γhis plan includes th | e medically r | needy. |
| | | 1 | _/ No. | | |
| | | 1 | <u>X</u> / Yes. T | his plan cove | ers the following groups: |
| | | | • | Pregnant w | omen and children. |
| | | | | | eept for income and/or resources, would be edy under title XIX of the Act. |
| 1902(e) of t Act | the | 2 | Medicaid and State plan on be eligible, as postpartum se | receive Med the date the though they ervices under regnancy en | ant, were eligible for and have applied for icaid as medically needy under the approved pregnancy ends. These women continue to were pregnant, for all pregnancy-related and the plan for a 60-day period, beginning with ds, and any remaining days in the month in |
| 1902(a)(10) (C) (ii)(I) of the Act |) 3 | . І | | | at for income and/or resources, ction 1902(a)(10)(A)(i)of the Act. |
| *Agency tha | at determ | ines el | ligibility for coverage |) . | |
| D1014261 | | | | | |
| | | | | | |
| TN No. 2005 Supersedes | <u>5-5</u> | | Approval Da | ite | Effective Date |
| TN No. <u>92-6</u> | <u></u> | | | | HCFA ID: 7983E |

Revision: HCFA-PM-91-4 (BPD)

1991

ATTACHMENT 2.2-A

Page 26 OMB No: 0938-

| | State <u>:</u> | Tennesse |) | |
|------------------------------|----------------|----------|---------------------|--|
| Agency* Ci | itations(s) | | Gr | oups Covered |
| | C. | Optio | al Coverage of the | Medically Needy (Continued) |
| 42 CFR 435.31 | 0 /_/ | 6. | Caretaker relatives | 3. |
| 42 CFR 435.32 and 435.330 | 0 /_/ | 7. | Aged individuals. | |
| 42 CFR 435.32 and 435.330 | 2 / <u>/</u> / | 8. | Blind individuals. | |
| 42 CFR 435.32 And 435.330 | 4 /_/ | 9. | Disabled individua | s. |
| 42 CFR 435.32 | 6 /_/ | 10. | HMO. Categorical | ould be ineligible if they were not enrolled in an ly needy individuals are covered under 42 the same rules apply to medically needy |
| 435.340 | | 11. | Blind and disabled | individuals who: |
| | | | | rrent requirements for Medicaid eligibility blindness or disability criteria; |
| | | | • | ole as medically needy in December 1973 as sabled; and |
| | | | | consecutive month after December 1973 o meet the December 1973 eligibility criteria. |

^{*}Agency that determines eligibility for coverage.

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|----------------------|---------------|----------------|--|
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| TN No. <u>92-6</u> | | HCFA ID: 7983E | |



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to Come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-6 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to eliminate coverage for over the counter drugs, limit prescriptions to four (4) for Medicaid adults, and institute co-pays for Medicaid adults. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. [*This document will be attached when the SPA is submitted to CMS]*. We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

| TRANSMITTAL AND NOTICE OF APPROVAL OF | 1. TRANSMITTAL NUMBER: | 2. STATE |
|--|--|--------------------|
| | 2005-6 | TENNESSEE |
| STATE PLAN MATERIAL | | |
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 3. PROGRAM IDENTIFICATION: TI' SOCIAL SECURITY ACT (MEDIC | |
| | ` | mid) |
| TO: REGIONAL ADMINISTRATOR | 4. PROPOSED EFFECTIVE DATE | |
| HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | |
| 3. TTE OF TENT MITTERINE (Cheek One). | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE C | CONSIDERED AS NEW PLAN | ☐ AMENDMENT |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | | h amendment) |
| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: | Φ |
| 42 CFR 440 and 441 | a. FFY 2004/2005 b. FFY 2005/2006 | \$ \$ |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: | 9. PAGE NUMBER OF THE SUPERS | |
| Attachment 3.1.A.1, Item 12. | OR ATTACHMENT (If Applicable) | |
| Attachment 3.1.B.1, Item 12 | Attachment 3.1.A.1, Item 12. | |
| | Attachment 3.1.B.1, Item 12. | |
| | | |
| | | |
| 10. SUBJECT OF AMENDMENT: | | |
| Limitation on Amount, Duration and Scope of Medical Care and Ser | vices Provided – Prescribed Drugs. | |
| • | - | |
| 11. GOVERNOR'S REVIEW (Check One): | | |
| X GOVERNOR'S OFFICE REPORTED NO COMMENT | ☐ OTHER, AS SPECI | IFIED: |
| COMMENTS OF GOVERNOR'S OFFICE ENCLOSED | | |
| ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: | |
| | Tennessee Department of Finance | and Administration |
| 13. TYPED NAME: J. D. Hickey | Bureau of TennCare | |
| 13. TTEB WANE. V. B. THOKOY | 729 Church Street | |
| 14. TITLE: Deputy Commissioner | Nashville, Tennessee 37247-6501 | |
| 17. DATE OLIDIMETED | Attention: George Woods | |
| 15. DATE SUBMITTED: | 3 | |
| FOR REGIONAL OF | FFICE USE ONLY | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | |
| DI AM ADDROVED ON | E CODY ATTACHED | |
| PLAN APPROVED – ON 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OF | FICIAI · |
| 13. EFFECTIVE DATE OF AFFROVED MATERIAL. | 20. SIGNATURE OF REGIONAL OF | FICIAL. |
| 21. TYPED NAME: | 22. TITLE: | |
| 22 DEMARKS | | |
| 23. REMARKS: | | |
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| LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL |
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| CARE AND SERVICES PROVIDED |

12. Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician skilled in diseases of the eye or by an optometrist.

12.a. Prescribed drugs

- (1) Prescription outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Social Security Act will be a covered benefit for all Medicaid eligible TennCare members when prescribed by an authorized licensed prescriber, unless coverage is excluded or otherwise restricted by TennCare in accordance with the following:
 - As provided by Section 1927(d) of the Social Security Act, hereinafter (a) referred to as the Act, the following drugs or classes of drugs or their medical uses are allowed to be excluded from coverage or otherwise restricted: agents when used for anorexia or weight control, agents when used to promote fertility, agents when used for cosmetic purposes or hair growth, agents when used for the symptomatic relief of coughs and colds, agents when used to promote smoking cessation, nonprescription or "over-the-counter" ("OTC") drugs, even when prescribed by a physician, covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee, and drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (DESI, IRS and LTE) as described in Section 1903(i)(5) of the Social Security Act. TennCare will exclude from coverage all of the allowable exclusions described above. with the exception of OTC drugs prescribed as medically necessary for individuals under the age of 21, and pre-natal vitamins prescribed for pregnant women.
 - (b) Services or treatment received from Methadone treatment clinics will be excluded from coverage.
 - (c) Coverage of prescription drugs for adult beneficiaries 21 years of age or older, who are not receiving services in a nursing facility (or other facility for institutional care) or enrolled in a Home and Community Based Services (HCBS) waiver, will be limited to four prescriptions per

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month. This coverage limitation shall not apply to medications or supplies included on the list attached to this State Plan as Attachment I, or to such other medications as may subsequently be designated by the State through appropriate policy issuances, and of which pharmacies, providers and beneficiaries shall be made aware through appropriate notice.

- (2) No payment will be made for an innovator multiple source drug (brand name drug) if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug. In the event a prescriber indicates on the face of the prescription ("dispense as written") that he/she is requiring a specific brand name drug be dispensed for a specific TennCare member or if a TennCare member appeals coverage of a generic drug and the appeals process results in approval of a specific brand name drug, then the reimbursement methodology for that prescription will the same as that for innovator single source drugs covered under the TennCare pharmacy program.
- (3) A prior approval system for drugs requiring prior authorization will comply with Section 1927 of the Act and be administered by the pharmacy benefits manager (PBM) or pharmacy benefits administrator (PBA) under contract to TennCare to provide those services. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
- (4) Participating pharmaceutical manufacturers will be furnished drug rebate utilization data and allowed to audit this data as set forth and according to the Centers for Medicare and Medicaid Services (CMS) guidelines pursuant to the Act.
- (5) As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

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- As specified in section 1927(b)(3)(D) of the Act, notwithstanding any other provision of law, information disclosed by manufacturers shall not be disclosed by the State in a form which discloses the identity of a specific manufacturer or prices charged for drugs by such manufacturers, except as the Secretary determines to be necessary and/or to permit the Comptroller General to review the information provided.
- (7) Separate agreements between the State and the manufacturers require CMS authorization. The State has CMS authorization for the collection of supplemental rebates that are negotiated with pharmaceutical manufacturers pursuant to the TennCare preferred drug list (PDL) as required by the Act. TennCare will report supplemental rebates from separate agreements to CMS.
- (8) The state is in compliance with Section 1927 of the Social Security Act, except insofar as the State may have obtained a waiver of § 1902(a)(54) of the Social Security Act under § 1115 to authorize noncompliance with certain provisions of § 1927 for specific purposes related to carrying out a federally approved demonstration project. Except as otherwise specifically provided in this State Plan, the state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and applicable restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on August 13, 2003 and entitled, "State of Tennessee Supplemental Rebate Agreement," has been authorized by CMS.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

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All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

- (9) Adult beneficiaries 21 years of age or older shall be liable for nominal cost sharing in the expense of outpatient pharmacy services afforded to them under the State Plan, and shall be obligated to make nominal co-payments when receiving covered prescription drugs from a pharmacy or other provider, with the exception of generic drugs included on the State's preferred drug list and drugs in categories that have not been reviewed for the inclusion in the preferred drug list. Pharmacies or providers shall collect all applicable TennCare-required copays from TennCare members. Failure to make an applicable co-payment will not be a basis for delay or denial of any of the services described in Section 1916(a)(2) of the Social Security Act or implementing regulations at 42 C.F.R. 447.53(b). Services cannot be denied to any eligible recipient because of the individual's inability to pay the co-payment. This requirement does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the co-payment charges. A recipient is deemed unable to pay the copayment if the recipient states to the pharmacist that he or she cannot pay. The amount of such co-payment will be \$1.00 for each prescription filled of a branded drug on the State's preferred drug list, and \$3.00 for non-preferred medications. Certain enrollees will be exempt from copay obligations, in accordance with 42 CFR 447.53(b).
- (10) In accordance with the provisions of the Act, TennCare began the development and implementation of a preferred drug list (PDL) on July 1, 2003. TennCare will move to a single, statewide preferred drug list (PDL) for the entire pharmacy program. Furthermore, TennCare will employ a single pharmacy benefits manager (PBM) to process all TennCare pharmacy claims and respond to all prior approval requests.

Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

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Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

- (11) Except as otherwise specifically provided in this State Plan, when a provider with prescribing authority prescribes a covered medication for a TennCare member, and the prescription is presented at a pharmacy that participates in the TennCare program, the member is entitled to either:
 - (a) The drug as prescribed, if the drug is covered by TennCare and does not require prior authorization; or
 - (b) The drug as prescribed, if the prescribing provider has obtained prior authorization; or
 - (c) An alternative medication, if the pharmacist consults the prescribing provider when the member presents the prescription to be filled, and the provider prescribes the substituted drug; or
 - (d) An emergency supply of the prescribed drug, if the pharmacist is unable, when the member presents the prescription to be filled, to obtain authorization from either TennCare or the designated TennCare point-of-sale (POS) pharmacy claims processor to fill the prescription as written or the prescribing provider's authorization to substitute an alternative medication. If the member does not receive the medication of the type and amount prescribed, the pharmacist shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal, as required by the *Grier* Revised Consent Decree. The member's entitlement to receive an emergency supply of the prescribed drug is subject to the provisions as set out below.
- (12) The member is entitled to an emergency supply of the prescribed drug provided that:

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- (a) The manufacturer has a rebate agreement and the medication is not classified by the FDA or regarded by CMS to be less than effective (DESI, LTE or IRS drug); or
- (b) The medication is not a drug in a non-covered TennCare therapeutic category or class of drugs or products such as: agents used for anorexia, weight loss or weight gain, agents used to promote fertility, agents not listed on the TennCare preferred drug list used for the symptomatic relief of cough and colds, agents used for cosmetic purposes or hair growth, agents used to promote smoking cessation, agents not listed on the TennCare drug preferred drug list which are prescription vitamins and mineral products, agents not listed on the TennCare preferred drug list which are nonprescription (over-the-counter) products and drugs. TennCare will exclude from coverage all of the allowable exclusions described above; or
- (c) Use of the medication has not been determined to be medically contraindicated because of the member's medical condition or possible adverse drug interaction; or
- (d) The prescriber did not prescribe a total quantity less than an emergency supply, in which case the pharmacist must provide a supply up to the amount prescribed.
- (13) There are some cases in which it is not feasible for the pharmacist to dispense an emergency supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging (inhalers, eye drops, topicals, etc.). When coverage of an emergency supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense an emergency supply, it shall be the responsibility of TennCare to provide coverage for either the emergency supply or the usual dispensing amount, whichever is greater.
- (14) Pharmacies should bill prescriptions for TennCare members with other third party insurance to the appropriate third party payer (primary insurer) and bill any applicable copays for covered drugs to TennCare.

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- (15) Covered drugs under the TennCare Pharmacy Program shall be limited to drugs that meet one or more of the following criteria and are not excluded by any of the following criteria:
 - (a) Those legend drugs covered under the Medicaid Drug Rebate Program as described in Section 1927 (k) of the Social Security Act and outlined in the TennCare Pharmacy Program Preferred drug list.
 - (b) Legend and non-legend drugs which are covered and prescribed by an authorized prescriber and which may not be dispensed over the counter without a prescription, except this limitation of coverage shall not apply in the case of a child under the age of 21 for whom an over-the-counter (OTC) drug has been prescribed as medically necessary by a licensed medical professional, or to coverage of pre-natal vitamins when prescribed for a pregnant woman.
 - (c) Those drugs which are not included in the list of excluded therapeutic categories or classes contained in Section 1927(d) of the Social Security Act and listed above in (12)(a)(1); and except to the extent such drugs may be expressly excepted from non-coverage or designated as covered under certain circumstances or for certain categories of beneficiaries under any provision of this State Plan.
 - (d) Those drugs not considered to be DESI, less-than-effective (LTE) or identical, related or similar (IRS) to DESI drugs.
 - (e) Drugs that are included on the State's formulary, except, where applicable, in a case where prior authorization is obtained for coverage of any such drug.
 - (f) Drugs that are not designated as excluded from coverage under Section 12.a.(1) or any other provision of this State Plan.
 - (g) Drugs that are not prescribed under circumstances, or for individuals, for which their use is designated as non-covered under Section 12.a.(1) or any other provision of this State Plan.

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Attachment I Pharmacy Shortlist

Medications that will continue to be available to patients **in an outpatient setting** (if provided by a participating health care provider) even after the physician office visit or outpatient facility visit limit has been reached **or** that will **not** count toward the 4 prescription limit when obtained through a participating retail pharmacy:

Specified drugs for the treatment of renal disease (iron preparations and dialysis medications)

TPN

Antineoplastic agents

Clotting factors

Antiviral agents specific to HIV treatment

Drugs specific to the treatment of Hep C

Drugs specific to the treatment of tuberculosis

Flu vaccine for high risk individuals

Prenatal vitamins

This list has been developed in consultation with state health associations, attempting to take into account the following factors:

- (1) actual budget constraints;
- (2) associated severity of illness;
- (3) likelihood that the patient will require multiple drugs; and
- (4) abuse potential and current utilization levels.

Equipment and Supplies that will not count toward any limit and that will continue to be covered **in an outpatient setting** even after other benefit limits have been hit:

Home infusion supplies Diabetic supplies Asthma supplies

Important Note:

The Shortlist is a living document. As new medications become available that fall into the same or similar categories to those already on the list, they will be considered for inclusion on the list. In addition, the list will be reviewed in the regularly in the context of budget constraints and operational compliance and could be expanded or reduced based on the results of such review. State health associations will be involved in decision-making.

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| | HIC3 Description | | Examples of Paid Claims | HIC3 Coding | HICL coding |
|----------------------|--|--|--|----------------|-------------|
| Clotting Factors | Antihemophilic Factors | Factor VIIa | Novoseven | MOE | 011639 |
| Clotting ractors | Antinemophilic ractors | Factor VII | Advate | MOE | 011418 |
| | | 1 actor vii | Recombinate | MOE | 011418 |
| | | | Kogenate FS | MOE | 011418 |
| | | | Helixate FS | M0E | 011418 |
| | | | Refacto | M0E | 011418 |
| | | Anti inhibitor Cooquiant Compley | | MOE | 002740 |
| | | Anti-inhibitor Coagulant Complex | Autoplex T | MICE | |
| | | | Fieba VH Immuno | M0E | 002740 |
| | | Antihemophilic factor/von Willebrand factor | Humate-P | M0E | 017395 |
| | | Antihemophilic factor | Alphanate | MOE | 011417 |
| | | | Hemofil-M | M0E | 011417 |
| | Factor IX Preparations | Factor IX | Benefix | MOF | 012793 |
| | · | | Bebulin VH | MOF | 002741 |
| | | | Mononine | MOF | 021313 |
| | | | Alphanine SD | MOF | 021313 |
| | | | 7 tip://dimino 62 | | 02.0.0 |
| Iron Preparations | Hematinic, other | Epoetin | Procrit | N1B | 004553 |
| ii oii i repurutiono | Trematine, other | Epocuii | Epogen | N1B | 004553 |
| | | Darbepoetin | Aranesp | N1B | 048578 |
| | Iron replacement | Iron Dextran | Infed | C3B | 000733 |
| | Tron replacement | Hon Dexiran | DexFerrum | C3B | 000733 |
| | | Cadium Famia Olyanata | | | |
| | | Sodium Ferric Gluconate Complex | Ferrlecit | СЗВ | 019948 |
| | | Iron Sucrose | Venofer | СЗВ | 021773 |
| Dialysis Medications | Electolyte Depleters | | Calcium Acetate | C1A | 004884 |
| | | | Sevelamar (Renagel) | C1A | 018832 |
| | | | SPS (Kayexalate) | C1A | 013209 |
| | Vitamin B preps | | FA/Vit B Complex with C (Nephrocap) | C6B | 001061 |
| Anti-Virals | Antivirals, HIV Specific, Protease Inhibitor | Protease Inhibitors | Invirase | W5C | 024470 |
| | | | Fortovase | W5C | 016624 |
| | | | Norvir | W5C | 010412 |
| | | | Crixivan | W5C | 010683 |
| | | | Viracept | W5C | 030366 |
| | | | Lexiva | W5C | 025662 |
| | | | Agenerase | W5C | 021177 |
| | | | Agenerase | W5C | 019079 |
| | | | Reyataz | W5C | 025390 |
| | Antivirals, HIV specific, Protease Inhibitor Combo | Protease Inhibitor Combos | Kaletra | W5M | 021582 |
| | Antivirals, HIV specific, nucleotide analog RTI | Nucleotide Analog Reverse Trans Inhibitor | Viread | W5I | 022937 |

| | Antivirals, HIV specific nucleoside analog RTI | Nucleoside Rev Transcript Inhibitor | Videx | W5J | 011013, 006508, 006510, 006221 |
|-------------|---|--|---|------|---|
| | | | Epivir | W5J | 024417 |
| | | | Zerit | W5J | 009060 |
| | | | Hivid | W5J | 006408 |
| | | | Retrovir | | 000408 |
| | | | | W5J | 018857 |
| | | | Ziagen | W5J | |
| | | | Emtriva | W5J | 025426 |
| | Antivirals HIV specific nucleoside analog RTI combo | Nucleoside analog Reverse Trans Inhibitor | Combivir | W5L | 014014 |
| | | | Trizivir | W5L | 021800, 022982 |
| | | | Epzicom | W5L | 026524 |
| | Antiviral HIV specific nucleoside/nucleotide combo | Nucleoside/nucleotide combo | Truvada | W5O | 026515 |
| | Antivirals HIV specific non- nucleoside RTI | Non-nucleoside reverse trans inhibitor | Viramune | W5K | 011592 |
| | | | Rescriptor | W5K | 012954 |
| | | | Sustiva | W5K | 018748 |
| | Antivirals HIV specific fuseon inhibitor | Fuseon inhibitors | Fuzeon | W5N | 025044 |
| | Antivirals assoc with HIV | General antivirals | Foscavir | W5A | 013221 |
| | | | Cytovene (PO + IV) | W5A | 009644 |
| | | | Valcyte | W5A | 022033 |
| | | | Vistide | W5A | 011506 |
| | Eye antivirals | Eye antivirals | Vitravene | Q6V | 018834 |
| | Lyo anaviraio | Lyo anaviraio | Vitrasert | Q6V | 009644 |
| | | | Titidooit | QU. | 000011 |
| Flu Vaccine | Influenza virus vaccines | | Influenza tri/split | W7C | |
| Tiu vaccine | I I I I I I I I I I I I I I I I I I I | | imideriza til/spiit | **** | |
| Hepatitis C | Hepatitis C treatment agents | | Peg-interferon alfa-2a (Pegasys) | W5G | 024035 |
| | | | Peg-interferon alfa-2b | W5G | 021367 |
| | | | Ribavirin (Rebetrol) | W5G | 004184 |
| | | | Interferon alfa-2b and ribivirin (Rebetron) | W5G | 018438 |
| | | | Interferon alfacon-1 (Infergen) | W5G | 015707 |
| | | | | | |

| | | | Interferon alfa-2a | Z2G | 004527 |
|------------------------|------------------------------|---|--|---|--|
| | | | (Roferon-A) | | |
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| | | | Interferon alfa-2b | Z2G | 004528 |
| | | | | 226 | 004526 |
| | | | (Intron A) | | |
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| Anti-tubercular Agents | Anti-mycobacterium | | Isoniazid | W2E | 004080 |
| taboroular / gorito | | | Rifabutin | W2E | 007626 |
| | | | | | 001020 |
| | | | Pyrazinamide | W2E | 004084 |
| | | | Ethambutol | W2E | 004085 |
| | | | Ethionamide | W2E | 004086 |
| | | | Aminosalicylic acid | W2E | 004081, |
| | | | Aminosalicylic acid | *** | 004082, |
| | | | | | 004002, |
| | | | | | 004083 |
| | | | | | |
| | Antitubercular antibiotics | | Rifamate | W1G | 004039 |
| | | | Rifater | W1G | 006296 |
| | | | | | |
| | | | Rifampin | W1G | 004040 |
| | | | Cycloserine | W1G | 004038 |
| | | | Capreomycin | W1G | 004037 |
| | | | Rifapentine | W1G | 018831 |
| | A series a select a seriel a | | | | |
| | Aminoglycoside | | Streptomycin | W1F | 004027 |
| | | | | | |
| Antineoplastics | Alkylating agents | Nitrogen mustards | Chlorambucil | V1A | 003894 |
| ' | , , , | <u> </u> | Cyclophosphamide | V1A | 003893 |
| | | | Cyclophicophamiae | * | 000000 |
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| | | | | | |
| | | | Ifosfamide | V1A | 004570, |
| | | | | | 003903 |
| | | | | | |
| | | | Mechlorethamine | V1A | 004570, |
| | | | | • ., . | 003892 |
| | i | | | | 003082 |
| | | | | | |
| | | | Molphalan | \/4 A | 007945 |
| | | | Melphalan | V1A | 007845, |
| | | | Melphalan | V1A | 007845, 003895 |
| | | | | | 003895 |
| | | Nitrosureas | Carmustine | V1A | 003895 |
| | | | Carmustine Lomustine | V1A V1A | 003895 003901 003900 |
| | | | Carmustine Lomustine | V1A V1A | 003895 003901 003900 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan | V1A V1A V1A | 003895 003901 003900 003899 |
| | | | Carmustine Lomustine | V1A V1A | 003895 003901 003900 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan | V1A V1A V1A | 003895 003901 003900 003899 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan Altretamine | V1A V1A V1A V1A | 003895 003901 003900 003899 006041 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan Altretamine | V1A V1A V1A V1A | 003895 003901 003900 003899 006041 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin | V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines Platinum Coordination Complex | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin Oxaliplatin | V1A V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 003902 016687 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin | V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |

| | | Imidozatatrozina Darivativas | Tomozolomido | V1A | 020355 |
|--------------|-----------------------------|-------------------------------|---------------------------|-----|-------------------|
| | | Imidazotetrazine Derivatives | Temozolomide | VIA | 020355 |
| | Steroid antineoplastics | Estrogen/Nitrogen Mustard | Estramustine phos sod | V1E | 003924 |
| _ | | Androgens | Testolactone | V1E | 003922 |
| | Antibiotic anti-neoplastics | Antibiotic anti-neoplastics | Streptozocin | V1D | 003920 |
| | | | Bleomycin | V1D | 003918 |
| | | | Dactinomycin | V1D | 003914 |
| | | | Mitomycin | V1D | 003917 |
| | | Antibiotics, anthracyclines | Daunorubicin HCL | V1D | 003919 |
| | | | Daunorubicin liposomal | V1D | 010804 |
| | | | Doxorubicin | V1D | 003916 |
| | | | Doxorubicin, liposomal | V1D | 010222 |
| | | | Epirubicin | V1D | 006578 |
| | | | Idarubicin | V1D | 006024 |
| | Antineoplastics, Misc | Triazenes | Dacarbazine | V1F | 003927 |
| | | Taxoids | Paclitaxel | V1F | 010166, 007625 |
| | | | Docetaxel | V1F | 010280 |
| | | Podophyllotoxin Derivatives | Etoposide | V1F | 011549, 003930 |
| | | | Teniposide | V1F | 004811 |
| | | Aromatase Inhibitors | Anastrozole | V1F | 010249 |
| | | | Letrozole | V1F | 012351 |
| | | | Exemestane | V1F | 020803 |
| | | Enzymes | Asparaginase | V1F | 003929 |
| | | | Pegaspargase | V1F | 008904 |
| | | Anthracenedione | Mitoxantrone | V1F | 003932 |
| | | Methylhydrazine Derivatives | Procarbazine | V1F | 003928 |
| | | DNA Topoisomerase Inhibitors | Irinotecan | V1F | 010778 |
| | | | Topotecan | V1F | 011381 |
| | | Biological Response Modifiers | Aldesleukin | Z2G | 006402 |
| | | | BGC, Intravesical | V1F | 004219 |
| | | | Denileukin Diftitox | V1F | 019075 |
| | | | Levamisole | Z2G | 005811 |
| | | Retinoids, antineoplastics | Tretinoin (Vesanoid only) | V1F | 002468 |
| | | Rexinoids | Bexarotene | V1N | 020832 |
| | | | | Q5N | 020832 |
| | | | Alitretinoin | Q5N | 019074 |
| | | Misc | Mitotane | V1F | 003925 |
| | | | Porfimer | V1R | 011790 |

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|----------|-----------------------|--|-----------------------|----------|-------------------|
| | | | Talc Powder, sterile | V1S | 002321 |
| | | | Abarelix | V1V | 025850 |
| | | | Arsenic trioxide | V1F | 021734 |
| | Antimetabolites | Folic Acid Antagonists | Methotrexate | V1B | 003905, |
| | | 3 | | | 003906, |
| | | | | | 024819 |
| | | | Pemetrexed | V1B | 025905 |
| | | Pyrimidine analogs | Capecitabine | V1B | 018385 |
| | | | Gemcitabine | V1B | 010798 |
| | | | Cytarabine | V1B | 003910 |
| | | | Cytarabine, liposomal | V1B | 020270 |
| | | | Fluorouracil | V1B | 003907 |
| | | | Floxuridine | V1B | 003907 |
| | | Purine analogs and related | Cladribine | V1B | 003909 |
| | | agents | Cladibilie | V15 | 007040 |
| | | | Fludarabine | V1B | 006308 |
| | | | Mercaptopurine | V1B | 003908 |
| | | | Pentostatin | V1B | 006304 |
| | | | Thioguanine | V1B | 003911 |
| | | DNA demethylation agents | Azacitidine | V1B | 026361 |
| | Antimitotic agents | Vinca alkaloids | Vinblastine | V1C | 003912 |
| | 7 transitione agente | Viriod direction | Vincristine | V1C | 003913 |
| | | | Vinorelbine | V1C | 009614 |
| | Hormones | Antiandrogens | Bicalutamide | V1J | 010143 |
| | | | Flutamide | V1J | 003933 |
| | | | Nilutamide | V1J | 007876 |
| | | Antiestrogen | Tamoxifen | V1T | 003926 |
| | | | Toremifene | V1T | 011632 |
| | | | Fulvestrant | V1T | 023523 |
| | | Gonadotropin-releasing | Leuprolide | V10 | 023323 |
| | | hormone analog | Leapronde | • 10 | 021102 |
| | | | Goserelin | V10 | 021114 |
| | | | Triptorelin | V10 | 023164 |
| | Radiopharmaceuticals | Radiopharmaceuticals | Strontium-89 | V1G | 008779 |
| | | | Samarium SM 153 | V1G | 013440 |
| | Cytoprotective agents | Chemotherapy rescue/antidote | Amifostine | V1I | 010704, |
| | Cytoprotective agents | agent | Amiosune | V | 013015 |
| | | | Dexrazoxane | V1I | 009997 |
| | | | Mesna | V1I | 003934 |
| | | | Leucovorin | V1I | 001063 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Rituximab | V1K | 016848 |
| | | | Ibritumomab | V1K | 023335, 023334 |
| | | | Trastuzumab | V1K | 018801 |

| Alembuzumab VIK 02911 | | | | | | |
|--|---|---|---|----------------------|-----|-------------------|
| Tosiumomab VIK 02443 Zevalin VIK 02443 Antineoplastic egi receptor blooker romb mc antibody Antineoplastic hum vegi inhibitor From mc antibody Protein tyrosine kinase inhibitors Antineoplastic systemic enzyme inhibitor Epidermal growth factor receptor inhibitor Inhibitor Proteasome inhibitors HERIFECFR tyrosine kinase Endotrib VIQ 02501 HERIFECFR tyrosine kinase Endotrib VIQ 2674 Inhibitors Glucose regulating and monitoring agents HICL=006373, GSN=19756, 6373 Alcohol pads HICL=004220, 025583 Alcohol pads HICL=004220, 025583 Alcohol pads HICL=004220, 025583 Alcohol pads HICL=004220, 025084, 023084, 023044, 024300, 024299, gsn=6372 Syringes HICL=004327, 023038, 023041, 023040, 024315, 025117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenatal Vitamin preparations Prenate, Zenate, etc. C6F | | | | | V1K | 021218 |
| Zevalin | | | | Alemtuzumab | | |
| December Continue | | | | | | |
| Antineoplastic egi receptor blocker romb me antibody blocker romb me antibody blocker romb me antibody blocker romb me antibody recomb me antibody recomb me antibody recomb me antibody blocker romb me antibody recomb me antibody recomb me antibody blocker romb me antibody recomb me antibody blocker romb me antibody blocker receptor inhibitors. Protein tyrosine kinase inhibitors. Antineoplastic systemic enzyme inhibitor. Epidermal growth factor receptor inhibitors. Proteasome inhibitors. Bortezomib V1Q 025202 blocker. V1Q 02502 blocker. Proteasome inhibitors. Proteasom | | | | Zevalin | V1K | 024430, 024431 |
| Antineoplastic egi receptor blocker romb me antibody blocker romb me antibody blocker romb me antibody blocker romb me antibody recomb me antibody recomb me antibody recomb me antibody blocker romb me antibody recomb me antibody recomb me antibody blocker romb me antibody recomb me antibody blocker romb me antibody blocker receptor inhibitors. Protein tyrosine kinase inhibitors. Antineoplastic systemic enzyme inhibitor. Epidermal growth factor receptor inhibitors. Proteasome inhibitors. Bortezomib V1Q 025202 blocker. V1Q 02502 blocker. Proteasome inhibitors. Proteasom | | | | | V1U | 025481 |
| Protein tyrosine kinase inhibitors Protein tyrosine kinase inhibitors Antineoplastic systemic enzyme inhibitor Epidermal growth factor receptor inhibitor Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors HERTIEGFR tyrosine kinase inhibitors HERTIEGFR tyrosine kinase inhibitors HERTIEGFR tyrosine kinase inhibitors HICL=006373, GSN=19756, 6373 Glucose regulating and monitoring agents HICL=006373, GSN=19756, 6373 Lancets HICL=004422, 025583 Alcohol pads HICL=004422, 025583 Alcohol pads HICL=004278, 023088, 097894, 024300, 024299, gsn=6372 Syringes HICL=004276, 023038, 023041, 024304, 024300, 024299, gsn=6372 Syringes HICL=004327, 023038, 023041, 024316, 024100, 023404, 024316, 022117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenate, Zenate, etc. C6F | | | Antineoplastic egf receptor blocker rcmb mc antibody | Cetuximab | | 025947 |
| Epidermal growth factor receptor inhibitors Epidermal growth factor receptor inhibitors Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors HERIZEGFR tyrosine kinase inhibitors HERIZEGFR tyrosine kinase inhibitors HICL=006373, GSN=19756, 6373 Glucose regulating and monitoring agents HICL=004422, 025683 Alcohol pads HICL=004422, 025683 Alcohol pads HICL=004266 Glucose control solution HICL=023579, GSN=19415 Meters HICL=002748, 023088, 007894, 024300, 024299, gsn=6372 Syringes HICL=004327, 023038, 023041, 0230307, 023042, 0230314, 024100, 023040, 024315, 025117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenatal Vitamin preparations Prenate, Zenate, etc. C6F | | | Antineoplastic hum vegf inhibitor recomb mc antibody | Bevacizumab | V1X | 025963 |
| Inhibitors | | Protein tyrosine kinase inhibitors | | Imatinib | V1Q | 022096 |
| HERT/EGFR tyrosine kinase Erlotinib V1Q 26748 inhibitors | | Epidermal growth factor receptor inhibitors | | Cefitinib | V1Q | 025178 |
| HER1/EGFR tyrosine kinase inhibitors | | Proteasome Inhibitors | | Bortezomib | | 025202 |
| Calucose regulating and monitoring agents HiCL=006373, GSN=19756, 6373 | | | | Erlotinib | V1Q | 26745 |
| Lancets | | | | | | V1Q |
| Alcohol pads HICL=004266 Glucose control solution HICL=023579, GSN=19415 Meters HICL=002748, 023088, 007894, 024300, 024299. gsn=6372 Syringes HICL=004327, 023038, 023041, 023039, 023037, 023042, 023039, 023037, 023042, 023039, 023037, 023042, 024100, 023040, 024315, 025117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenate, Zenate, etc C6F | Glucose regulating and monitoring agents | Test strips | | | | |
| Alcohol pads HICL=004266 Glucose control solution HICL=023579, GSN=19415 Meters HICL=002748, 023088, 007894, 024300, 024299. gsn=6372 Syringes HICL=004327, 023038, 023041, 023039, 023037, 023042, 023039, 023037, 023042, 023039, 023037, 023042, 024100, 023040, 024315, 025117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenate, Zenate, etc C6F | | | | | | |
| Glucose control solution | | Lancets | HICL=004422, 025583 | | | |
| Glucose control solution | | | | | | |
| Meters | | Alcohol pads | HICL=004266 | | | |
| Meters | | Glucose control solution | HICI =023579 GSN=19415 | | | |
| Syringes | | 0.00000 | | | | |
| 023039, 023037, 023042, 023043, 024314, 024100, 023040, 024315, 025117, 025118 | | Meters | | | | |
| 023039, 023037, 023042, 023043, 024314, 024100, 023040, 024315, 025117, 025118 | | | | | | |
| | | Syringes | 023039, 023037, 023042, 023043, 024313, 024314, 024100, 023040, 024315, | | | |
| | | | | | | |
| Asthma Spacers Y7A 009021 | Prenatal vitamins | Prenatal Vitamin preparations | | Prenate, Zenate, etc | C6F | |
| Asthma Spacers Y7A 009021 | | | | | | |
| Asthma Spacers Y7A 009024 | | | | | | |
| | Asthma Spacers | | | | Y7A | 009021 |
| | | | | | | |

Attachment 3.1.A.1

| Large Volume Parenterals | | | | |
|--|--|----------|--|--|
| Coded by large volume fluid for quantities > 500ml, any additive will be covered | | | | |
| Will be covered | | | | |
| Sodium Chloride | HICL 008254, 008643, GSN 1210, 1209 | | | |
| Dextrose | HIC3 of C5K, C5L, C5M, HICL 000915, 000929 | | | |
| Lactated Ringers | HIC3 of C1W | | | |
| Sterile Water | GSN 1166 | | | |
| | | | | |
| TPN | | | | |
| Coded by Amino Acid, all additives will be covered | | | | |
| | | | | |
| Amino Acids | HIC3 of C5B | | | |
| | | | | |
| Heplock | | | | |
| | | | | |
| Heplock of 10u/ml or 100u/ml | GSN 6551, 6552, 6531, 6532, 6541, 6542, 18063 | | | |
| | <u></u> | <u> </u> | | |
| Saline Flush | · · | · | | |
| Coded up to 30cc vials | GSN 1218, 1221, HICL 003794 | | | |

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| 12. | Prescribed drugs, | dentures, | and | prosthetic | devices; | and | eyeglasses | prescribed | by | a | physician |
|-----|---------------------|------------|-------|------------|----------|-----|------------|------------|----|---|-----------|
| | skilled in diseases | of the eye | or by | y an optom | etrist. | | | | | | |

12.a. Prescribed drugs

- (1) Prescription outpatient drugs of any manufacturer which has entered into and complies with an agreement under Section 1927(a) of the Social Security Act will be a covered benefit for all Medicaid eligible TennCare members when prescribed by an authorized licensed prescriber, unless coverage is excluded or otherwise restricted by TennCare in accordance with the following:
 - As provided by Section 1927(d) of the Social Security Act, hereinafter (a) referred to as the Act, the following drugs or classes of drugs or their medical uses are allowed to be excluded from coverage or otherwise restricted: agents when used for anorexia or weight control, agents when used to promote fertility, agents when used for cosmetic purposes or hair growth, agents when used for the symptomatic relief of coughs and colds, agents when used to promote smoking cessation, nonprescription or "over-the-counter" ("OTC") drugs, even when prescribed by a physician, covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests and monitoring services be purchased exclusively from the manufacturer or its designee, and drugs described in Section 107(c)(3) of the Drug Amendments of 1962 and identical, similar, or related drugs (DESI, IRS and LTE) as described in Section 1903(i)(5) of the Social Security Act. TennCare will exclude from coverage all of the allowable exclusions described above. with the exception of OTC drugs prescribed as medically necessary for individuals under the age of 21, and pre-natal vitamins prescribed for pregnant women.
 - (b) Services or treatment received from Methadone treatment clinics will be excluded from coverage.
 - (c) Coverage of prescription drugs for adult beneficiaries 21 years of age or older, who are not receiving services in a nursing facility (or other facility for institutional care) or enrolled in a Home and Community Based Services (HCBS) waiver, will be limited to four prescriptions per

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month. This coverage limitation shall not apply to medications or supplies included on the list attached to this State Plan as Attachment I, or to such other medications as may subsequently be designated by the State through appropriate policy issuances, and of which pharmacies, providers and beneficiaries shall be made aware through appropriate notice.

- (2) No payment will be made for an innovator multiple source drug (brand name drug) if, under applicable State law, a less expensive multiple source drug could have been dispensed, but only to the extent that such amount exceeds the upper payment limit for such multiple source drug. In the event a prescriber indicates on the face of the prescription ("dispense as written") that he/she is requiring a specific brand name drug be dispensed for a specific TennCare member or if a TennCare member appeals coverage of a generic drug and the appeals process results in approval of a specific brand name drug, then the reimbursement methodology for that prescription will the same as that for innovator single source drugs covered under the TennCare pharmacy program.
- (3) A prior approval system for drugs requiring prior authorization will comply with Section 1927 of the Act and be administered by the pharmacy benefits manager (PBM) or pharmacy benefits administrator (PBA) under contract to TennCare to provide those services. The prior authorization process provides for a turnaround response by either telephone or other telecommunications device within twenty-four hours of receipt of a prior authorization request. In emergency situations, providers may dispense at least a seventy-two hour supply of medication.
- (4) Participating pharmaceutical manufacturers will be furnished drug rebate utilization data and allowed to audit this data as set forth and according to the Centers for Medicare and Medicaid Services (CMS) guidelines pursuant to the Act.
- (5) As provided by the Act, a new drug manufactured by a company which has entered into a rebate agreement may be covered subject to prior approval, unless the drug is subject to the allowable exclusion categories provided by the Act.

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- (6) As specified in section 1927(b)(3)(D) of the Act, notwithstanding any other provision of law, information disclosed by manufacturers shall not be disclosed by the State in a form which discloses the identity of a specific manufacturer or prices charged for drugs by such manufacturers, except as the Secretary determines to be necessary and/or to permit the Comptroller General to review the information provided.
- (7) Separate agreements between the State and the manufacturers require CMS authorization. The State has CMS authorization for the collection of supplemental rebates that are negotiated with pharmaceutical manufacturers pursuant to the TennCare preferred drug list (PDL) as required by the Act. TennCare will report supplemental rebates from separate agreements to CMS.
- (8) The state is in compliance with Section 1927 of the Social Security Act, except insofar as the State may have obtained a waiver of § 1902(a)(54) of the Social Security Act under § 1115 to authorize noncompliance with certain provisions of § 1927 for specific purposes related to carrying out a federally approved demonstration project. Except as otherwise specifically provided in this State Plan, the state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and applicable restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification.

The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates.

A rebate agreement between the state and a drug manufacturer for drugs provided to the Medicaid program, submitted to CMS on August 13, 2003 and entitled, "State of Tennessee Supplemental Rebate Agreement," has been authorized by CMS.

Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement.

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All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement.

- (9) Adult beneficiaries 21 years of age or older shall be liable for nominal cost sharing in the expense of outpatient pharmacy services afforded to them under the State Plan, and shall be obligated to make nominal co-payments when receiving covered prescription drugs from a pharmacy or other provider, with the exception of generic drugs included on the State's preferred drug list and drugs in categories that have not been reviewed for the inclusion in the preferred drug list. Pharmacies or providers shall collect all applicable TennCare-required copays from TennCare members. Failure to make an applicable co-payment will not be a basis for delay or denial of any of the services described in Section 1916(a)(2) of the Social Security Act or implementing regulations at 42 C.F.R. 447.53(b). Services cannot be denied to any eligible recipient because of the individual's inability to pay the co-payment. This requirement does not apply to an individual who is able to pay. An individual's inability to pay does not eliminate his or her liability for the co-payment charges. A recipient is deemed unable to pay the copayment if the recipient states to the pharmacist that he or she cannot pay. The amount of such co-payment will be \$1.00 for each prescription filled of a branded drug on the State's preferred drug list, and \$3.00 for non-preferred medications. Certain enrollees will be exempt from copay obligations, in accordance with 42 CFR 447.53(b).
- (10) In accordance with the provisions of the Act, TennCare began the development and implementation of a preferred drug list (PDL) on July 1, 2003. TennCare will move to a single, statewide preferred drug list (PDL) for the entire pharmacy program. Furthermore, TennCare will employ a single pharmacy benefits manager (PBM) to process all TennCare pharmacy claims and respond to all prior approval requests.

Pursuant to 42 U.S.C. Section 1396r-8 the state is establishing a preferred drug list with prior authorization for drugs not included on the preferred drug list. Prior authorization will be provided with a 24-hour turn-around from receipt of request and a 72-hour supply of drugs in emergency situations.

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Prior authorization will be established for certain drug classes, particular drugs or medically accepted indication for uses and doses.

The state will appoint a Pharmaceutical and Therapeutic Committee or utilize the drug utilization review committee in accordance with Federal law.

- (11) Except as otherwise specifically provided in this State Plan, when a provider with prescribing authority prescribes a covered medication for a TennCare member, and the prescription is presented at a pharmacy that participates in the TennCare program, the member is entitled to either:
 - (a) The drug as prescribed, if the drug is covered by TennCare and does not require prior authorization; or
 - (b) The drug as prescribed, if the prescribing provider has obtained prior authorization; or
 - (c) An alternative medication, if the pharmacist consults the prescribing provider when the member presents the prescription to be filled, and the provider prescribes the substituted drug; or
 - (d) An emergency supply of the prescribed drug, if the pharmacist is unable, when the member presents the prescription to be filled, to obtain authorization from either TennCare or the designated TennCare point-of-sale (POS) pharmacy claims processor to fill the prescription as written or the prescribing provider's authorization to substitute an alternative medication. If the member does not receive the medication of the type and amount prescribed, the pharmacist shall immediately provide written notice of the right to appeal, including the right to request continuation of services pending appeal, as required by the *Grier* Revised Consent Decree. The member's entitlement to receive an emergency supply of the prescribed drug is subject to the provisions as set out below.
- (12) The member is entitled to an emergency supply of the prescribed drug provided that:

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LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

- (a) The manufacturer has a rebate agreement and the medication is not classified by the FDA or regarded by CMS to be less than effective (DESI, LTE or IRS drug); or
- (b) The medication is not a drug in a non-covered TennCare therapeutic category or class of drugs or products such as: agents used for anorexia, weight loss or weight gain, agents used to promote fertility, agents not listed on the TennCare preferred drug list used for the symptomatic relief of cough and colds, agents used for cosmetic purposes or hair growth, agents used to promote smoking cessation, agents not listed on the TennCare drug preferred drug list which are prescription vitamins and mineral products, agents not listed on the TennCare preferred drug list which are nonprescription (over-the-counter) products and drugs. TennCare will exclude from coverage all of the allowable exclusions described above; or
- (c) Use of the medication has not been determined to be medically contraindicated because of the member's medical condition or possible adverse drug interaction; or
- (d) The prescriber did not prescribe a total quantity less than an emergency supply, in which case the pharmacist must provide a supply up to the amount prescribed.
- (13) There are some cases in which it is not feasible for the pharmacist to dispense an emergency supply because the drug is packaged by the manufacturer to be sold as the original unit or because the usual and customary pharmacy practice would be to dispense the drug in the original packaging (inhalers, eye drops, topicals, etc.). When coverage of an emergency supply of a prescription would otherwise be required and when, as described above, it is not feasible for the pharmacist to dispense an emergency supply, it shall be the responsibility of TennCare to provide coverage for either the emergency supply or the usual dispensing amount, whichever is greater.
- (14) Pharmacies should bill prescriptions for TennCare members with other third party insurance to the appropriate third party payer (primary insurer) and bill any applicable copays for covered drugs to TennCare.

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| LIMITATION ON AMOUNT, | DURATION AND | SCOPE OF N | MEDICAL |
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- (15) Covered drugs under the TennCare Pharmacy Program shall be limited to drugs that meet one or more of the following criteria and are not excluded by any of the following criteria:
 - (a) Those legend drugs covered under the Medicaid Drug Rebate Program as described in Section 1927 (k) of the Social Security Act and outlined in the TennCare Pharmacy Program Preferred drug list.
 - (b) Legend and non-legend drugs which are covered and prescribed by an authorized prescriber and which may not be dispensed over the counter without a prescription, except this limitation of coverage shall not apply in the case of a child under the age of 21 for whom an over-the-counter (OTC) drug has been prescribed as medically necessary by a licensed medical professional, or to coverage of pre-natal vitamins when prescribed for a pregnant woman.
 - (c) Those drugs which are not included in the list of excluded therapeutic categories or classes contained in Section 1927(d) of the Social Security Act and listed above in (12)(a)(1), except to the extent such drugs may be expressly excepted from non-coverage or designated as covered under certain circumstances or for certain categories of beneficiaries under any provision of this State Plan.
 - (d) Those drugs not considered to be DESI, less-than-effective (LTE) or identical, related or similar (IRS) to DESI drugs.
 - (e) Drugs that are included on the State's formulary, except, where applicable, in a case where prior authorization is obtained for coverage of any such drug.
 - (f) Drugs that are not designated as excluded from coverage under Section 12.a.(1) or any other provision of this State Plan.
 - (g) Drugs that are not prescribed under circumstances, or for individuals, for which their use is designated as non-covered under Section 12.a.(1) or any other provision of this State Plan.

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Attachment I Pharmacy Shortlist

Medications that will continue to be available to patients **in an outpatient setting** (if provided by a participating health care provider) even after the physician office visit or outpatient facility visit limit has been reached **or** that will **not** count toward the 4 prescription limit when obtained through a participating retail pharmacy:

Specified drugs for the treatment of renal disease (iron preparations and dialysis medications)

TPN

Antineoplastic agents

Clotting factors

Antiviral agents specific to HIV treatment

Drugs specific to the treatment of Hep C

Drugs specific to the treatment of tuberculosis

Flu vaccine for high risk individuals

Prenatal vitamins

This list has been developed in consultation with state professional associations, attempting to take into account the following factors:

- (1) actual budget constraints;
- (2) associated severity of illness;
- (3) likelihood that the patient will require multiple drugs; and
- (4) abuse potential and current utilization levels.

Equipment and Supplies that will not count toward any limit and that will continue to be covered **in an outpatient setting** even after other benefit limits have been hit:

Home infusion supplies Diabetic supplies Asthma supplies

Important Note:

The Shortlist is a living document. As new medications become available that fall into the same or similar categories to those already on the list, they will be considered for inclusion on the list. In addition, the list will be reviewed in the regularly in the context of budget constraints and operational compliance and could be expanded or reduced based on the results of such review. State health associations will be involved in decision-making.

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| | HIC3 Description | | Examples of Paid Claims | HIC3 Coding | HICL coding |
| Clotting Factors | Antihemophilic Factors | Factor VIIa | Novoseven | MOE | 011639 |
| Glotting Fuotoro | 7 with officering is detero | Factor VII | Advate | MOE | 011418 |
| | | 1 40101 711 | Recombinate | MOE | 011418 |
| | | | Kogenate FS | MOE | 011418 |
| | | | Helixate FS | MOE | 011418 |
| | | | Refacto | MOE | 011418 |
| | | Anti-inhibitor Coagulant Complex | Autoplex T | MOE | 002740 |
| | | | | | |
| | | | Fieba VH Immuno | MOE | 002740 |
| | | Antihemophilic factor/von Willebrand factor | Humate-P | MOE | 017395 |
| | | Antihemophilic factor | Alphanate | MOE | 011417 |
| | | | Hemofil-M | MOE | 011417 |
| | Factor IX Preparations | Factor IX | Benefix | MOF | 012793 |
| | · | | Bebulin VH | MOF | 002741 |
| | | | Mononine | MOF | 021313 |
| | | | Alphanine SD | MOF | 021313 |
| | | | r | | |
| Iron Preparations | Hematinic, other | Epoetin | Procrit | N1B | 004553 |
| | 1, 11 | ļ | Epogen | N1B | 004553 |
| | | Darbepoetin | Aranesp | N1B | 048578 |
| | Iron replacement | Iron Dextran | Infed | C3B | 000733 |
| | | | DexFerrum | C3B | 000733 |
| | | Sodium Ferric Gluconate Complex | Ferrlecit | C3B | 019948 |
| | | Iron Sucrose | Venofer | СЗВ | 021773 |
| Dialysis Medications | Floatelyte Depleters | | Calcium Acetate | C1 A | 004994 |
| Dialysis Medications | Electolyte Depleters | | Sevelamar (Renagel) | C1A C1A | 004884 018832 |
| | | | | | |
| | | | SPS (Kayexalate) | C1A | 013209 |
| | Vitamin B preps | | FA/Vit B Complex with C (Nephrocap) | C6B | 001061 |
| Anti-Virals | Antivirals, HIV Specific, Protease Inhibitor | Protease Inhibitors | Invirase | W5C | 024470 |
| | | | Forta : a a a | 14/50 | 046004 |
| | | | Fortovase | W5C | 016624 |
| | | | Norvir | W5C | 010412 |
| | | | Crixivan | W5C | 010683 |
| | | | Viracept | W5C | 030366 |
| | | | Lexiva | W5C | 025662 |
| | | | Agenerase | W5C | 021177 |
| | | | Agenerase | W5C | 019079 |
| | | D / 1 | Reyataz | W5C | 025390 |
| | Antivirals, HIV specific, Protease Inhibitor Combo | Protease Inhibitor Combos | Kaletra | W5M | 021582 |
| | Antivirals, HIV specific, nucleotide analog RTI | Nucleotide Analog Reverse Trans Inhibitor | Viread | W5I | 022937 |

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| Inhibitor | | | | | | |
|---|-------------|--|--|------------------------------------|--------|---|
| Zent W5J 005 Hivid W5J 005 Retrovir W5J 005 Ziagen W5J 001 Emtriva W5J 001 Trizivir W5L 001 Trizivir W5L 001 Antivirals HIV specific nucleoside analog Reverse analog Reverse analog RTI combor Trizivir W5L 001 Antiviral HIV specific Nucleoside/nucleotide combo Trivada W5O 002 Antivirals HIV specific non-nucleoside reverse trans inhibitor Rescriptor W5K 001 Antivirals HIV specific fuseon inhibitor Fuseon inhibitor Fuseon inhibitor Fuseon inhibitor Fuseon Antivirals HIV specific fuseon inhibitor Fuseon inhibitor Fuseon W5N 002 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Eye antivirals Eye antivirals Fuseon Fuseo | | Antivirals, HIV specific nucleoside analog RTI | Nucleoside Rev Transcript Inhibitor | Videx | W5J | 011013, 006508, 006510, 006221 |
| Zent W5J 005 Hivid W5J 005 Retrovir W5J 005 Ziagen W5J 001 Emtriva W5J 001 Trizivir W5L 001 Trizivir W5L 001 Antivirals HIV specific nucleoside analog Reverse analog Reverse analog RTI combor Trizivir W5L 001 Antiviral HIV specific Nucleoside/nucleotide combo Trivada W5O 002 Antivirals HIV specific non-nucleoside reverse trans inhibitor Rescriptor W5K 001 Antivirals HIV specific fuseon inhibitor Fuseon inhibitor Fuseon inhibitor Fuseon inhibitor Fuseon Antivirals HIV specific fuseon inhibitor Fuseon inhibitor Fuseon W5N 002 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Antivirals assoc with HIV General antivirals Foscavir W5A 001 Eye antivirals Eye antivirals Fuseon Fuseo | | | | Fatito | \A/F 1 | 004447 |
| Hivid WSJ 000 Retrovir WSJ 001 Ziagen WSJ 011 Emitriva WSJ 001 Emitriva WSJ 001 Emitriva WSJ 001 Emitriva WSJ 0021 Antivirals HIV specific nucleoside analog Reverse Combivir WSL 0021 Trizivir WSL 0021 Trizivir WSL 0021 Trizivir WSL 0021 Trizivir WSL 0021 Antiviral HIV specific Epzicom WSL 0022 Antiviral HIV specific Nucleoside/nucleotide combo Truvada WSO 0026 Antivirals HIV specific non-nucleoside reverse trans Viramune WSK 011 Trizivir WSL 0021 Antivirals HIV specific fuse Non-nucleoside reverse trans Viramune WSK 011 Antivirals HIV specific fuse Fuse Sustiva WSK 011 Antivirals HIV specific fuse Fuse Fuse WSK 012 Antivirals HIV specific fuse Fuse Fuse WSK 012 Antivirals HIV specific fuse Fuse Fuse WSK 013 Antivirals HIV specific fuse Fuse Fuse WSK 014 Antivirals HIV specific fuse Fuse Fuse WSK 015 Antivirals HIV specific Fuse Fuse Fuse WSK 015 Antivirals HIV specific Fuse | | | | | | 024417 |
| Retrovir WSJ 00- Ziagen WSJ 01- Antivirals HIV specific nucleoside analog Reverse analog RTI combo Antiviral HIV specific nucleoside analog Reverse Trans inhibitor Antiviral HIV specific nucleoside/nucleotide combo Antiviral HIV specific nucleoside/nucleotide combo Antivirals HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific fuseon Fuseon inhibitors Antivirals HIV specific fuseon Fuseon inhibitors Antivirals HIV specific fuseon Fuseon inhibitors Antivirals Antivirals Bive specific fuseon Fuseon inhibitors Fuseon inhibitor Fuseon WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Cytovene (PO + IV) WSA 00: Vistore (PO + IV) WSA 00: Fuseon inhibitor Fuseon WSA 02: WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antivirals Assoc with HIV General antivirals Foscavir WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: Antiviral HIV specific non-nucleoside reverse trans inhibitor WSA 01: | | | | | | 009060 |
| Ziagen WSJ 015 | | | | | | 006408 |
| Antivirals HIV specific nucleoside analog Reverse analog RTI combo Nucleoside analog Reverse Trans Inhibitor Nucleoside analog RTI combo Nucleoside analog Reverse Trans Inhibitor Trizivir WSL 021 | | | | | | 004185 |
| Antivirals HIV specific nucleoside analog Reverse Trans Inhibitor Trizivir WSL 021 | | | | | | 018857 |
| analog RTI combo Trans Inhibitor Trizivir WSL 021 022 Antiviral HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific non-nucleoside reverse trans inhibitor Rescriptor W5K 01: Rescriptor W5K 01: Antivirals HIV specific fuseon Fuseon inhibitors Fuseon W5N 02: Antivirals HIV specific fuseon Fuseon inhibitors Fuseon W5N 02: Antivirals Antivirals Antivirals Sessoc with HIV General antivirals Foscavir W5A 01: Cytovene (PO + IV) W5A 00: W5A 01: Vistade W5A 01: Eye antivirals Eye antivirals Vitravene 06V 01: Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Interferon alfa-2b and ribivirin (Rebetrol) W5G 01: Interferon alfa-2b and ribivirin (Rebetron) W5G 01: | | | | | | 025426 |
| Antiviral HIV specific nucleoside/nucleotide combo Antiviral HIV specific nucleoside/nucleotide combo Antivirals HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific non-nucleoside reverse trans inhibitor Rescriptor W5K 01: Rescriptor W5K 01: Antivirals HIV specific fuseon inhibitors Fuseon inhibitors Antivirals HIV specific fuseon inhibitors Antivirals Antivirals Antivirals HIV general antivirals Antivirals assoc with HIV General antivirals Antivirals Antivirals Eye antivirals Foscavir W5A 01: Cytovene (PO + IV) W5A 00: W5A 02: W5A 01: Valcyte W5A 02: Valcyte W5A 02: Visitide W5A 01: Eye antivirals Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b and ribivirin (Rebetrol) W5G 01: Interferon alfa-2b and w5G 01: | | | | Combivir | W5L | 014014 |
| Antiviral HIV specific nucleoside/nucleotide combo Antivirals HIV specific non-nucleoside reverse trans inhibitor Antivirals HIV specific non-nucleoside reverse trans inhibitor Rescriptor W5K 012 Rescriptor W5K 013 Antivirals HIV specific fuseon inhibitors Antivirals HIV specific fuseon inhibitors Fuseon inhibitor Antivirals assoc with HIV General antivirals Foscavir W5A 013 Cytovene (PO + IV) W5A 003 Visitide W5A 013 Eye antivirals Vitravene Q6V 014 Eye antivirals Eye antivirals Vitravene Q6V 014 Flu Vaccine Influenza virus vaccines Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Ribavirin (Rebetrol) W5G 014 Ribavirin (Rebetrol) W5G 015 Ribavirin (Rebetrol) W5G 016 Interferon alfa-2b and ribivirin (Rebetron) W5G 016 | | | | | W5L | 021800, 022982 |
| Antivirals HIV specific non- nucleoside RTI Antivirals HIV specific non- nucleoside RTI Rescriptor Rescriptor W5K 012 Rescriptor W5K 013 Antivirals HIV specific fuseon inhibitor Fuseon inhibitors Antivirals HIV specific fuseon inhibitor Antivirals assoc with HIV General antivirals Cytovene (PO + IV) W5A 013 Cytovene (PO + IV) W5A 003 Valcyte W5A 014 Valcyte W5A 015 Eye antivirals Eye antivirals Eye antivirals Flu Vaccine Influenza virus vaccines Influenza tri/split Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Ribavirin (Rebetron) W5G 016 Interferon alfa-2b and ribivirin (Rebetron) | | | | Epzicom | W5L | 026524 |
| nucleoside RTI inhibitor Rescriptor Sustiva WSK 012 Antivirals HIV specific fuseon inhibitors inhibitor Antivirals assoc with HIV General antivirals Foscavir WSA 013 Antivirals assoc with HIV General antivirals Foscavir WSA 013 Cytovene (PO + IV) WSA 003 Valcyte WSA 021 Valcyte WSA 021 Vistide WSA 011 Eye antivirals Eye antivirals Vitravene QCV 014 Eye antivirals Eye antivirals Vitravene QCV 016 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b WSG 021 Ribavirin (Rebetron) WSG 016 Interferon alfa-2b and ribivirin (Rebetron) WSG 016 Interferon alfa-2b and ribivirin (Rebetron) WSG 016 | | Antiviral HIV specific nucleoside/nucleotide combo | Nucleoside/nucleotide combo | | W5O | 026515 |
| Antivirals HIV specific fuseon inhibitors Inhibitor Antivirals assoc with HIV General antivirals Fuseon inhibitors Antivirals assoc with HIV General antivirals Foscavir W5A O15 Cytovene (PO + IV) W5A O05 Valcyte W5A O17 Cytovene (PO + IV) W5A O18 Vistatide W5A O17 Eye antivirals Eye antivirals Fuseon inhibitors Fuseon inhibitors Foscavir W5A O17 Cytovene (PO + IV) W5A O18 Vistatide W5A O17 Influenza tri/split W7C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G O27 Ribavirin (Rebetrol) W5G O18 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) | | Antivirals HIV specific non- nucleoside RTI | | Viramune | W5K | 011592 |
| Antivirals HIV specific fuseon inhibitors Inhibitor Antivirals assoc with HIV Antivirals assoc with HIV General antivirals Fuzeon Antivirals Antivirals assoc with HIV General antivirals Foscavir W5A O13 Cytovene (PO + IV) W5A O22 Valcyte W5A O22 Vistide W5A O11 Eye antivirals Eye antivirals Eye antivirals Vitravene Q6V O16 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G O22 Ribavirin (Rebetrol) W5G O16 Interferon alfa-2b and ribivirin (Rebetron) | | | | Rescriptor | W5K | 012954 |
| inhibitor Antivirals assoc with HIV General antivirals Foscavir W5A 013 Cytovene (PO + IV) W5A 003 Valcyte W5A 022 Vistide W5A 011 Eye antivirals Eye antivirals Vitravene Q6V 018 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 024 Ribavirin (Rebetron) W5G 018 Interferon alfa-2b and ribivirin (Rebetron) W5G 018 | | | | | W5K | 018748 |
| Cytovene (PO + IV) W5A 009 Valcyte W5A 022 Visitide W5A 011 Eye antivirals Eye antivirals Vitravene Q6V 0118 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 022 Ribavirin (Rebetrol) W5G 004 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) | | | Fuseon inhibitors | Fuzeon | W5N | 025044 |
| Cytovene (PO + IV) W5A 009 Valcyte W5A 022 Visitide W5A 011 Eye antivirals Eye antivirals Vitravene Q6V 011 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 022 Ribavirin (Rebetrol) W5G 004 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) | | Antivirals assoc with HIV | General antivirals | Foscavir | W5A | 013221 |
| Eye antivirals Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G Ribavirin (Rebetrol) W5G O18 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) W5G O18 | | | | Cytovene (PO + IV) | W5A | 009644 |
| Eye antivirals Eye antivirals Eye antivirals Eye antivirals Vitravene Q6V O18 Vitravene Q6V O08 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G O24 Ribavirin (Rebetrol) W5G O18 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b w5G O18 | | | | Valcyte | W5A | 022033 |
| Eye antivirals Eye antivirals Vitravene Q6V 018 Vitrasert Q6V 008 Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 02 Ribavirin (Rebetrol) W5G 018 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2con-1 W5G 018 | | | | | W5A | 011506 |
| Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 02d Ribavirin (Rebetrol) W5G 018 Interferon alfa-2b and ribivirin (Rebetron) W5G 018 | | Eye antivirals | Eye antivirals | Vitravene | Q6V | 018834 |
| Flu Vaccine Influenza virus vaccines Influenza tri/split W7C Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 02² Ribavirin (Rebetrol) W5G 00² Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2con-1 W5G 018 | | | | | Q6V | 009644 |
| Hepatitis C Hepatitis C treatment agents Peg-interferon alfa-2a (Pegasys) Peg-interferon alfa-2b W5G 02² Ribavirin (Rebetrol) W5G 00² Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) Interferon alfa-2b and ribivirin (Rebetron) | | | | | | |
| (Pegasys) Peg-interferon alfa-2b W5G 02 ⁻² Ribavirin (Rebetrol) W5G 00 ⁻² Interferon alfa-2b and ribivirin (Rebetron) W5G 018 Interferon alfa-2b and ribivirin (Rebetron) W5G 018 | Flu Vaccine | Influenza virus vaccines | | | W7C | |
| Ribavirin (Rebetrol) W5G 004 Interferon alfa-2b and ribivirin (Rebetron) Interferon alfacon-1 W5G 018 | Hepatitis C | Hepatitis C treatment agents | | | W5G | 024035 |
| Interferon alfa-2b and ribivirin (Rebetron) Interferon alfacon-1 W5G 018 | | | | Peg-interferon alfa-2b | W5G | 021367 |
| ribivirin (Rebetron) Interferon alfacon-1 W5G 015 | | | | Ribavirin (Rebetrol) | W5G | 004184 |
| | | | | | W5G | 018438 |
| | | | | Interferon alfacon-1 (Infergen) | W5G | 015707 |

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| | I | | Interferon alfa-2a | Z2G | 004527 |
| | I | | (Roferon-A) | | |
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| | | | Interferon alfa-2b | Z2G | 004528 |
| | I | | (Intron A) | 220 | 004320 |
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| Anti-tubercular Agents | Anti-mycohacterium | | Isoniazid | W2E | 004080 |
| Anti-tubercular Agents | / and mycobacterium | | Rifabutin | W2E | 007626 |
| | | | | | |
| | | | Pyrazinamide | W2E | 004084 |
| | | | Ethambutol | W2E | 004085 |
| | | | Ethionamide | W2E | 004086 |
| | 1 | | Aminosalicylic acid | W2E | 004081, |
| | I | | | | 004082, |
| | I | | | | 004083 |
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| | Antitubercular antibiotics | | Rifamate | W1G | 004039 |
| | 7 thittaboroalar artiblotics | | Rifater | W1G | 006296 |
| | | | | W1G | 004040 |
| | | | Rifampin | | |
| | <u> </u> | | Cycloserine | W1G | 004038 |
| | | | Capreomycin | W1G | 004037 |
| | <u> </u> | | Rifapentine | W1G | 018831 |
| | Aminoglycoside | | Streptomycin | W1F | 004027 |
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| Antineoplastics | Alkylating agents | Nitrogen mustards | Chlorambucil | V1A | 003894 |
| | | | Cyclophosphamide | V1A | 003893 |
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| | I | | Ifosfamide | V1A | 004570, |
| | I | | | | 003903 |
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| | I | | Mechlorethamine | V1A | 004570, |
| | I | | | | 003892 |
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| | | | Melphalan | V1A | 007845, |
| | | | Melphalan | V1A | 007845, 003895 |
| | | N9 | | | 003895 |
| | | Nitrosureas | Carmustine | V1A | 003895 003901 |
| | | | Carmustine Lomustine | V1A V1A | 003895 003901 003900 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan | V1A V1A V1A | 003895 003901 003900 003899 |
| | | | Carmustine Lomustine | V1A V1A | 003895 003901 003900 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan | V1A V1A V1A | 003895 003901 003900 003899 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan Altretamine | V1A V1A V1A V1A | 003895 003901 003900 003899 006041 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 |
| | | Alkyl Sulfonates | Carmustine Lomustine Busulfan Altretamine | V1A V1A V1A V1A | 003895 003901 003900 003899 006041 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin | V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin | V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin | V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines Platinum Coordination Complex | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin Oxaliplatin | V1A V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 003902 016687 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin | V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines Platinum Coordination Complex | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin Oxaliplatin | V1A V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 003902 016687 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines Platinum Coordination Complex Substituted Ureas | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin Oxaliplatin Hydroxyurea | V1A V1A V1A V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 003902 016687 003897 |
| | | Alkyl Sulfonates Ethylenimines/Methylmelamines Platinum Coordination Complex | Carmustine Lomustine Busulfan Altretamine Thiotepa Carboplatin Cisplatin Oxaliplatin | V1A V1A V1A V1A V1A V1A V1A | 003895 003901 003900 003899 006041 003898 003905 003902 016687 |

Approval Date _____ Effective Date _____

| T | | | | |
|-----------------------------|-------------------------------|---------------------------|-----|-------------------|
| Steroid antineoplastics | Estrogen/Nitrogen Mustard | Estramustine phos sod | V1E | 003924 |
| | Androgens | Testolactone | V1E | 003922 |
| Antibiotic anti-neoplastics | Antibiotic anti-neoplastics | Streptozocin | V1D | 003920 |
| | | Bleomycin | V1D | 003918 |
| | | Dactinomycin | V1D | 003914 |
| | | Mitomycin | V1D | 003917 |
| | Antibiotics, anthracyclines | Daunorubicin HCL | V1D | 003919 |
| | | Daunorubicin liposomal | V1D | 010804 |
| | | Doxorubicin | V1D | 003916 |
| | | Doxorubicin, liposomal | V1D | 010222 |
| | | Epirubicin | V1D | 006578 |
| | | Idarubicin | V1D | 006024 |
| Antineoplastics, Misc | Triazenes | Dacarbazine | V1F | 003927 |
| | Taxoids | Paclitaxel | V1F | 010166, 007625 |
| | | Docetaxel | V1F | 010280 |
| | Podophyllotoxin Derivatives | Etoposide | V1F | 011549, 003930 |
| | | Teniposide | V1F | 004811 |
| | Aromatase Inhibitors | Anastrozole | V1F | 010249 |
| | | Letrozole | V1F | 012351 |
| | | Exemestane | V1F | 020803 |
| | Enzymes | Asparaginase | V1F | 003929 |
| | | Pegaspargase | V1F | 008904 |
| | Anthracenedione | Mitoxantrone | V1F | 003932 |
| | Methylhydrazine Derivatives | Procarbazine | V1F | 003928 |
| | DNA Topoisomerase Inhibitors | Irinotecan | V1F | 010778 |
| | | Topotecan | V1F | 011381 |
| | Biological Response Modifiers | Aldesleukin | Z2G | 006402 |
| | | BGC, Intravesical | V1F | 004219 |
| | | Denileukin Diftitox | V1F | 019075 |
| | | Levamisole | Z2G | 005811 |
| | Retinoids, antineoplastics | Tretinoin (Vesanoid only) | V1F | 002468 |
| | Rexinoids | Bexarotene | V1N | 020832 |
| | | 211111212119 | Q5N | 020832 |
| | | Alitretinoin | Q5N | 019074 |
| | Misc | Mitotane | V1F | 003925 |
| | | Porfimer | V1R | 011790 |
| | | Talc Powder, sterile | V1S | 002321 |
| | | | | |
| | | Abarelix | V1V | 025850 |

Approval Date _____ Effective Date ____

| | Antimetabolites | Folic Acid Antagonists | Methotrexate | V1B | 003905, |
|----------|-----------------------|--|--|---------------------------------|---|
| | | | | | 003906, |
| | | | | | 024819 |
| | | | Domotrovod | V1B | 025905 |
| | | Durimiding analogo | Pemetrexed Capecitabine | | 025905 |
| | | Pyrimidine analogs | Gemcitabine | V1B V1B | 010798 |
| | | | Cytarabine | V1B V1B | 003910 |
| | | | Cytarabine, liposomal | V1B V1B | 020270 |
| | | | Cytarabine, liposomai | * 15 | 020270 |
| | | | | | |
| | | | Fluorouracil | V1B | 003907 |
| | | | Floxuridine | V1B | 003909 |
| | | Purine analogs and related | Cladribine | V1B | 007840 |
| | | agents | | | |
| | | | Fludarabine | V1B | 006308 |
| | | | Mercaptopurine | V1B V1B | 00308 |
| | | | Pentostatin | V1B V1B | 006304 |
| | | | Thioguanine | V1B | 003911 |
| | | DNA demethylation agents | Azacitidine | V1B | 026361 |
| | | DIVA demetrylation agents | Azacılıdırıc | V.D | 020001 |
| | | | | | |
| <u> </u> | Antimitotic agents | Vinca alkaloids | Vinblastine | V1C | 003912 |
| | | | Vincristine | V1C | 003913 |
| | | | Vinorelbine | V1C | 009614 |
| | Hormones | Antiandrogens | Bicalutamide | V1J | 010143 |
| | | | Flutamide | V1J | 003933 |
| | | | | | |
| | | | Nilutamide | V1J | 007876 |
| | | Antiestrogen | Tamoxifen | V1T | 003926 |
| | | , unacon ogen | Tarrioxileri | * | 000020 |
| | | | | | |
| | | | | | |
| | | | Toremifene | V1T | 011632 |
| | | | Fulvestrant | V1T | 023523 |
| | | Gonadotropin-releasing | Leuprolide | V10 | 021994, |
| | | hormone analog | • | | 021102 |
| | | | 0 " | 1/40 | 004444 |
| | | | Goserelin | V10 | 021114 |
| | | | | | |
| | | | Triptorelin | V10 | 023164 |
| | Radiopharmaceuticals | Radiopharmaceuticals | Strontium-89 | V1G | 008779 |
| | | · | Samarium SM 153 | V1G | 013440 |
| | | | | | |
| | | | | | 212-21 |
| | Cytoprotective agents | Chemotherapy rescue/antidote | Amifostine | V1I | 010704, |
| | | agent | | | 013015 |
| | | | Dexrazoxane | V1I | 009997 |
| | | | Mesna | V1I | 003934 |
| | | | Leucovorin | V1I | 001063 |
| | | | | | 016848 |
| | Monoclonal antibodies | Antineoplastics | Rituximab I | V1K | U 10040 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Rituximab | V1K | 010040 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Rituximab | V1K | 010040 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Rituximab | V1K | 010040 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Rituximab | V1K | 023335, |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | | | |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab | V1K | 023335, 023334 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab Trastuzumab | V1K | 023335, 023334 018801 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab Trastuzumab Gemtuzumab | V1K V1K V1K | 023335, 023334 018801 021218 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab Trastuzumab Gemtuzumab Alemtuzumab | V1K V1K V1K V1K | 023335, 023334 018801 021218 022112 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab Trastuzumab Gemtuzumab Alemtuzumab Tositumomab | V1K V1K V1K V1K V1K | 023335, 023334 018801 021218 022112 025481 |
| | Monoclonal antibodies | Antineoplastics antibody/antibody drug complex | Ibritumomab Trastuzumab Gemtuzumab Alemtuzumab | V1K V1K V1K V1K | 023335, 023334 018801 021218 022112 |

TN No. 2005-6 Supersedes TN No. NEW

Approval Date _____ Effective Date _____

| Protein tyrosine kinase inhibitors Protein tyrosine kinase inhibitors Antineoplastic systemic enzyme inhibitor Epidermal growth factor receptor inhibitors Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors HERT/EGFR tyrosine kinase Enfotinib V1Q 025202 HERT/EGFR tyrosine kinase Enfotinib V1Q 267402 1681 | | | | | | |
|---|--|------------------------------------|---|----------------------|-----|--------|
| Antineoplastic hum vegl inhibitor Protein tyrosine kinase inhibitors Protein tyrosine kinase inhibitors Antineoplastic systemic enzyme inhibitor Epidermal growth factor receptor Antineoplastic systemic enzyme inhibitors Epidermal growth factor receptor Antineoplastic systemic enzyme inhibitors Proteasome inhibitors Proteasome inhibitors Proteasome inhibitors Proteasome inhibitors Proteasome inhibitors HECL=006373, GSN=19766, 6373 Giucose regulating and monitoring agents HICL=006373, GSN=19766, 6373 Alcohol pads HICL=00422, 025583 Alcohol pads HICL=004226 Giucose control solution HICL=023578, GSN=19415 Alcohol pads HICL=00422, 02568, 07884, 02488, 007884, 02489, gsn=6372 Syringes Prenate vitamins Prenate Vitamin preparations Prenate vitamins Prenate Vitamin preparations Prenate, Zenate, etc C6F Asthmus Spacers Y7A 009021 Large Volume Parenterals Codest by User volume find for quantilises > 500mt, any additive will be covered will | | | | | | |
| Protein tyrosine kinase inhibitors Protein tyrosine kinase inhibitors Epidermal growth factor receptor inhibitors Epidermal growth factor receptor inhibitors Proteasome Inhibitors Proteasome Inhibitors Proteasome Inhibitors HERNEGER tyrosine kinase Inhibitors HERNEGER tyrosine kinase Inhibitors HERNEGER tyrosine kinase Inhibitors Froteasome Inhibitors HICL=006373, GSN=19756, 6373 Proteasome Inhibitors HICL=006373, GSN=19756, 6373 Proteasome Inhibitors HICL=00422, 025883 Alcohol pads Alcohol pads HICL=004227, 025983 Alcohol pads HICL=004266 HICL=00428, 023088, 007894, 024300, 024299, gsn=6372 Syringes HICL=004327, 02308, 023041, 023039, 023042, 023030, 024314, 023030, 024315, 025117, 025118 Prenatal vitamins Prenatal Vitamin preparations Prenatal vitamins Prenatal Vitamin preparations Prenatal vitamins Prenatal vitamins preparations | | | Antineoplastic egf receptor blocker rcmb mc antibody | Cetuximab | V1W | 025947 |
| Epidermal growth factor receptor Antineoplastic systemic enzyme Ceffinib V1Q 025178 inhibitor Proteasome Inhibitors Proteasome Inhibitors Bortezomib V1Q 025202 HER1/EGFR tyrosine kinase inhibitors Frotinib V1Q 26745 HER1/EGFR tyrosine kinase inhibitors Frotinib V1Q 26745 MICL=006373, GSN=19756, 6373 W1Q GSN=19756, 6373 W1Q GSN=19756, 6373 W1Q GSN=19415 GSN=1 | | | Antineoplastic hum vegf inhibitor recomb mc antibody | Bevacizumab | V1X | 025963 |
| Inhibitors | | Protein tyrosine kinase inhibitors | | Imatinib | V1Q | 022096 |
| HERY/EGFR tyrosine kinase inhibitors | | | Antineoplastic systemic enzyme inhibitor | Cefitinib | V1Q | 025178 |
| HERY/EGFR tyrosine kinase inhibitors | | Proteasome Inhibitors | Proteasome Inhibitors | Bortezomib | V1Q | 025202 |
| HICL=006373, GSN=19756, 6373 | | | HER1/EGFR tyrosine kinase | | | 26745 |
| Lancets | Glucose regulating and | Test strips | | | | V1Q |
| Alcohol pads | monitoring agents | | 63/3 | | | |
| Alcohol pads | | | | | | |
| Glucose control solution | | Lancets | HICL=004422, 025583 | | | |
| Glucose control solution | | | 1,1101 00,1000 | | | |
| Meters | | Alcohol paus | FIICE-004200 | | | |
| D24300, 024299. gsn=6372 Syringes | | Glucose control solution | HICL=023579, GSN=19415 | | | |
| 023039, 023037, 023042, 023043, 024314, 024100, 023040, 024315, 025117, 025118 | | Meters | HICL=002748, 023088, 007894, 024300, 024299. gsn=6372 | | | |
| 023039, 023037, 023042, 023043, 024314, 024100, 023040, 024315, 025117, 025118 | | | | | | |
| Asthma Spacers Y7A 009021 Large Volume Parenterals Coded by large volume fluid for quantities > 500ml, any additive will be covered | | Syringes | 023039, 023037, 023042, 023043, 024313, 024314, 024100, 023040, 024315, | | | |
| Large Volume Parenterals Coded by large volume fluid for quantities > 500ml, any additive will be covered | Prenatal vitamins | Prenatal Vitamin preparations | | Prenate, Zenate, etc | C6F | |
| Coded by large volume fluid for quantities > 500ml, any additive will be covered | Asthma Spacers | | | | Y7A | 009021 |
| Coded by large volume fluid for quantities > 500ml, any additive will be covered | Large Volume Parenterals | | | | | |
| Sodium Chloride HICL 008254 008643 GSN | Coded by large volume fluid for quantities > 500ml, any additive | | | | | |
| | Sodium Chloride | HICL 008254, 008643, GSN | | | | |

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Approval Date _____ Effective Date ____

| | 1210, 1209 | | |
|------------------------------|-----------------------------|--|--|
| Dextrose | HIC3 of C5K, C5L, C5M, HICL | | |
| | 000915, 000929 | | |
| Lactated Ringers | HIC3 of C1W | | |
| Sterile Water | GSN 1166 | | |
| | | | |
| TPN | | | |
| Coded by Amino Acid, all | | | |
| additives will be covered | | | |
| | | | |
| Amino Acids | HIC3 of C5B | | |
| | | | |
| Heplock | | | |
| | | | |
| Heplock of 10u/ml or 100u/ml | GSN 6551, 6552, 6531, 6532, | | |
| | 6541, 6542, 18063 | | |
| _ | · | | |
| Saline Flush | · | | |
| Coded up to 30cc vials | GSN 1218, 1221, HICL 003794 | | |

Approval Date _____ Effective Date ____



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Renard L. Murray Associate Regional Administrator Division of Medicaid Centers for Medicare and Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, GA 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-7 is an amendment to the Tennessee Title XIX Medicaid State Plan, which is being forwarded to your office for review and approval. This plan amendment is being submitted to eliminate two drug classes. A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. [This document will be attached when the SPA is submitted to CMS.] We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Should you have any questions or need additional information, please contact Susie Baird at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1085013

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: 2005-7 | 2. STATE TENNESSEE | |
|--|--|-----------------------|--|
| FOR: HEALTH CARE FINANCING ADMINISTRATION | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE | | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSIDE | ERED AS NEW PLAN | NDMENT | |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | | endment) | |
| 6. FEDERAL STATUTE/REGULATION CITATION: | 7. FEDERAL BUDGET IMPACT: | Φ. | |
| 42 CFR 440 and 441 | a. FFY 2004/2005 b. FFY 2005/2006 | \$ \$ | |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1.A.1, Item 12, 12.a. (1)(d) Attachment 3.1.B.1, Item 12, 12.a. (1)(d) | 9. PAGE NUMBER OF THE SUPERSEDI OR ATTACHMENT (If Applicable): | | |
| 10. SUBJECT OF AMENDMENT: Limitation on Amount, Duration and Scope | e of Medical Care and Services Provided – Pre | scribed Drugs. | |
| 11. GOVERNOR'S REVIEW (Check One): X GOVERNOR'S OFFICE REPORTED NO COMMENT ☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED ☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | ☐ OTHER, AS SPECIFIED: | | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: | | |
| | Tennessee Department of Finance and A Bureau of TennCare | Administration | |
| 13. TYPED NAME: J. D. Hickey | 729 Church Street | | |
| 14 TITLE Day (Commissions | Nashville, Tennessee 37247-6501 | | |
| 14. TITLE: Deputy Commissioner | Attention: George Woods | | |
| 15. DATE SUBMITTED: | | | |
| FOR REGIONAL OF | ELCE TOP ONLY | | |
| FOR REGIONAL OF 17. DATE RECEIVED: | 18. DATE APPROVED: | | |
| | | | |
| PLAN APPROVED - ON | | [AT. | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICE | AL: | |
| 21. TYPED NAME: | 22. TITLE: | | |
| 23. REMARKS: | | | |
| | | | |
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| | | | |

STATE <u>TENNESSEE</u>

LIMITATION ON AMOUNT, DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

| 12. | Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a |
|-----|--|
| | physician skilled in diseases of the eye or by an optometrist. |

- 12.a. Prescribed drugs
 - (1)(d) TennCare will exclude from coverage all antihistamines and pharmaceutical products for the reduction of gastric acid, including H2 blockers and proton pump inhibitors, except when prescribed as medically necessary for individuals under the age of 21. There will be no exceptions to this coverage exclusion for adult beneficiaries.

D1095025

| TN No. <u>2005-7</u> | | |
|----------------------|---------------|----------------|
| Supersedes | Approval Date | Effective Date |
| TN. No. NEW | | |

STATE <u>TENNESSEE</u>

| LIMITATION ON AMOUNT, | DURATION AND SCOPE OF MEDICAL |
|-----------------------|-------------------------------|
| CARE AND | SERVICES PROVIDED |

| 12. | Prescribed drugs, dentures, and prosthetic devices; and eyeglasses prescribed by a |
|-----|--|
| | physician skilled in diseases of the eye or by an optometrist. |

- 12.a. Prescribed drugs
 - (1)(d) TennCare will exclude from coverage all antihistamines and pharmaceutical products for the reduction of gastric acid, including H2 blockers and proton pump inhibitors, except when prescribed as medically necessary for individuals under the age of 21. There will be no exceptions to this coverage exclusion for adult beneficiaries.

D1105025

| TN No. 2005-7 Supersedes TN. No. NEW | Approval Date | Effective Date |
|--|---------------|----------------|



STATE OF TENNESSEE DEPARTMENT OF FINANCE AND ADMINISTRATION BUREAU OF TENNCARE 729 CHURCH STREET NASHVILLE, TENNESSEE 37247-6501

[Date to come]

Mr. Renard Murray Associate Regional Administrator Division of Medicaid Centers for Medicare & Medicaid Services (CMS) Atlanta Federal Center 61 Forsyth Street, S.W., Suite 4T20 Atlanta, Georgia 30303-8909

Dear Mr. Murray:

Action Transmittal 2005-8 is an amendment to the Tennessee Title XIX State Plan which is being forwarded to your office for review and approval. The State of Tennessee has competitively secured the services of First Health Services Corporation to implement a preferred drug list/supplemental rebate program. This procurement was done through a competitive Request for Proposal process following state and federal guidelines for the procurement of services for Title XIX programs.

This State Plan Amendment is to allow for the collection of supplemental rebates from pharmaceutical manufacturers for the Medicaid program through the Michigan Multi-State Pooling Agreement (MMSPA) approved by CMS on April 22, 2004. The use of a preferred drug list and prior authorization program will increase the efficiency and economy of Medicaid operations and benefit the Medicaid population by holding down the rising cost of prescription coverage to the Medicaid program.

Through the procurement of the pharmacy benefit services, Tennessee has a choice of either developing state specific supplemental rebate contracts with pharmaceutical manufacturers, or becoming a participant in the MMSPA, that has been developed to allow States to pool their collective purchasing power to gain deeper discounts on prescription drugs for Medicaid beneficiaries. Through this State Plan Amendment, Tennessee is electing to join the MMSPA.

Mr. Renard Murray [Date to come] Page 2

The States that are currently participants in the MMSPA are Michigan, Vermont, New Hampshire, Nevada, Alaska, Montana, Minnesota, and Hawaii. Tennessee is seeking CMS approval to join these states in the MMSPA through the CMS approved process of adding States to the pool. Attached to Tennessee's State Plan Amendment is a copy of the "New Participating State Amendment to Supplemental Drug-Rebate Agreement between the States of Michigan, Vermont, New Hampshire, Alaska and Nevada: First Health Services Corporation and the Manufacturer". This document is the CMS approved template that will be used with each manufacturer to add Tennessee to the MMSPA.

Tennessee is also including Exhibit A1 indicating that Tennessee does not have any non-Medicaid programs approved by CMS in the Medicaid State Plan.

Following is the Supplemental Rebate Agreement Questions followed by appropriate TennCare response:

1. Does the state receive a supplemental rebate or any revenue back from manufacturers in addition to the national Medicaid rebate? If so, does the state reduce the Medicaid expenditures under the state plan by the amount of the rebates or revenue?

TennCare response:

Yes, the State receives additional supplemental rebate. The Medicaid expenditures under the State Plan are reduced by the amount of the rebate.

2. Does the state receive any goods, services or other benefits for their Medicaid covered population from the pharmaceutical manufacturer? Does the manufacturer provide these goods, services or other benefits for including the manufacturer's drugs on a Medicaid preferred drug list? Does the state receive goods or services from a manufacturer if the manufacturer's drugs are not subject to prior authorization?

TennCare response: No.

3. If the state receives goods or services from the manufacturer, what kinds of goods or services are provided? What is the value of these goods and services?

TennCare's response: Not applicable

4. Does the state share the savings realized by these manufacturer goods, services, revenues and rebates with the federal government by offsetting total computable Medicaid expenditures by the costs of these services?

TennCare's response: Not applicable

A copy of the public notice conducted in accordance with 42 CFR 447.205 is attached. *[This document will be attached when the SPA is submitted to CMS.]* We would appreciate the opportunity to work with you to coordinate the final effective date with the date of approval of our waiver amendment.

Mr. Renard Murray [Date to come] Page 3

I look forward to gaining approval from CMS for this State Plan Amendment, if additional information is needed or if you have any questions, please contact me at (615) 741-0213.

Sincerely,

J. D. Hickey Deputy Commissioner

JDH/D1025026

| TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL | 1. TRANSMITTAL NUMBER: 2005-8 | 2. STATE TENNESSEE |
|--|---|-----------------------|
| FOR: HEALTH CARE FINANCING ADMINISTRATION | | |
| | 3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID) | |
| TO: REGIONAL ADMINISTRATOR HEALTH CARE FINANCING ADMINISTRATION DEPARTMENT OF HEALTH AND HUMAN SERVICES | 4. PROPOSED EFFECTIVE DATE | |
| 5. TYPE OF PLAN MATERIAL (Check One): | | |
| ☐ NEW STATE PLAN X AMENDMENT TO BE CONSIDE | ERED AS NEW PLAN AMEN | IDMENT |
| COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AME | | endment) |
| 6. FEDERAL STATUTE/REGULATION CITATION: 42 CFR 440 and 441 | 7. FEDERAL BUDGET IMPACT: a. FFY 2004/2005 b. FFY 2005/2006 | \$ \$ |
| 8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT: Attachment 3.1.A.1, Item 12, 12.a. (8) Attachment 3.1.B.1, Item 12, 12.a. (8) | 9. PAGE NUMBER OF THE SUPERSEDE OR ATTACHMENT (If Applicable): Attachment 3.1.A.1, Item 12, 12.a. (8) Attachment 3.1.B.1, Item 12, 12.a. (8) | ED PLAN SECTION |
| 10. SUBJECT OF AMENDMENT: Limitation on Amount, Duration and Scope | of Medical Care and Services Provided – Pres | scribed Drugs. |
| 11. GOVERNOR'S REVIEW (Check One): X GOVERNOR'S OFFICE REPORTED NO COMMENT COMMENTS OF GOVERNOR'S OFFICE ENCLOSED NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL | ☐ OTHER, AS SPECIFIED: | |
| 12. SIGNATURE OF STATE AGENCY OFFICIAL: | 16. RETURN TO: Tennessee Department of Finance and A | Administration |
| 13. TYPED NAME: J. D. Hickey | Bureau of TennCare 729 Church Street Nashville, Tennessee 37247-6501 | |
| 14. TITLE: Deputy Commissioner | Attention: George Woods | |
| 15. DATE SUBMITTED: | | |
| FOR REGIONAL OF | FICE USE ONLY | |
| 17. DATE RECEIVED: | 18. DATE APPROVED: | |
| PLAN APPROVED – ON | E COPY ATTACHED | |
| 19. EFFECTIVE DATE OF APPROVED MATERIAL: | 20. SIGNATURE OF REGIONAL OFFICE | AL: |
| 21. TYPED NAME: | 22. TITLE: | |
| 23. REMARKS: | | |

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE $\underline{\text{TENNESSEE}}$

LIMITATION ON AMOUNT DURATION AND SCOPE OF MEDICAL CARE AND SERVICES PROVIDED

| 12. | | | ugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physician ases of the eye or by an optometrist. | |
|-----|-------|-------|--|--|
| | 12.a. | Presc | ibed drugs | |
| | | (8) | The state is in compliance with Section 1927 of the Social Security Act, except insofar as the State may have obtained a waiver of § 1902(a)(54) of the Social Security Act under § 1115 to authorize noncompliance with certain provisions of § 1927 for specific purposes related to carrying out a federally approved demonstration project. Except as otherwise specifically provided in this State Plan, the state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and applicable restrictions to coverage. Pharmaceutical manufacturers can audit utilization data. The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification. | |
| | | | The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a pharmaceutical manufacturer will be separate from the federal rebates. | |
| | | | CMS has authorized the state of Tennessee to enter into the Michigan multi-state pooling agreement. The Amendment to the Supplemental Drug Rebate Agreement was submitted to CMS on and has been authorized by CMS. | |
| | | | Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government on the same percentage basis as applied under the national rebate agreement. | |
| | | | All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement. | |

Approval Date _____ Effective Date _____

Supersedes

TÑ No. <u>2005-6</u>

STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT STATE <u>TENNESSEE</u> LIMITATION ON AMOUNT DURATION AND SCOPE OF MEDICAL

CARE AND SERVICES PROVIDED

| 12. | | | ugs, dentures, and prosthetic devices; and eyeglasses prescribed by a physiciar ases of the eye or by an optometrist. |
|-----|-------|--------|---|
| | 12.a. | Presci | ribed drugs |
| | | (8) | The state is in compliance with Section 1927 of the Social Security Act, except insofar as the State may have obtained a waiver of § 1902(a)(54) of the Social Security Act under § 1115 to authorize noncompliance with certain provisions of § 1927 for specific purposes related to carrying out a federally approved demonstration project. Except as otherwise specifically provided in this State Plan, the state will cover drugs of federal rebate participating manufacturers. The state is in compliance with reporting requirements for utilization and applicable restrictions to coverage. Pharmaceutical manufacturers can audit utilization data The unit rebate amount is confidential and cannot be disclosed for purposes other than rebate invoicing and verification. The state will be negotiating supplemental rebates in addition to the federal rebates provided for in Title XIX. Rebate agreements between the state and a |
| | | | pharmaceutical manufacturer will be separate from the federal rebates. CMS has authorized the state of Tennessee to enter into the Michigan multi-state pooling agreement. The Amendment to the Supplemental Drug Rebate Agreement was submitted to CMS on and has been authorized by CMS. |
| | | | Supplemental rebates received by the State in excess of those required under the national drug rebate agreement will be shared with the Federal government or the same percentage basis as applied under the national rebate agreement. |
| | | | All drugs covered by the program, irrespective of a prior authorization agreement, will comply with the provisions of the national drug rebate agreement. |

Supersedes TÑ No. <u>2005-6</u> Approval Date _____ Effective Date _____

New Participating State Amendment to Supplemental Drug-Rebate Agreement Between The States of Michigan, Vermont, New Hampshire, Alaska and Nevada; First Health Services Corporation And

(Manufacturer Name ("Manufacturer"))

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and Manufacturer have entered into a Supplemental Drug-Rebate Agreement (the "Agreement"), effective as of April 1, 2004; and

WHEREAS, the participating States as named in Section 8 below have become parties to the Agreement as Participating States by previous amendment or addenda; and

WHEREAS, additional states have indicated their willingness to become a new Participating State, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

Deleted:

Now, therefore, in consideration of the mutual covenants, promises, and conditions contained herein and in the Agreement, the parties agree as follows:

- 1. The State of Tennessee is hereby added as a party to the Agreement as a new Participating State, as defined in Section 3.14 of the Agreement.
- 2. This Amendment shall become effective upon the date determined in accordance with Section 3.16 of the Agreement.
- 3. An executed copy of this Amendment shall be sent via certified mail, return receipt requested to Manufacturer's address of record as set forth in the Agreement within five (5) business days of its execution by the parties. Any notice to Participating State shall be sent to the names and address in section 9 of this Exhibit:
- 4. This Addendum adds a new Participating State to the Agreement and does not otherwise change or alter the Agreement. The new Participating State(s) understand(s) and agrees to be bound by the terms of the Agreement.
- 5. The undersigned State acknowledges that manufacturer rebate pricing information is confidential information under applicable Federal law and shall be exempt from public disclosure pursuant to State Code Section 71-5-197.

- 6. The undersigned State represents that it has not requested authorization from CMS to include any state pharmaceutical assistance program within the rebate provisions of the Agreement. The above representation shall not prohibit the undersigned State from requesting CMS authorization to include (other) pharmaceutical assistance programs within the Agreement at a later date. Upon receipt of CMS authorization, State shall given written notice to Manufacturer of the date Manufacturer's Supplemental Covered Product is effectively placed on the preferred drug list of the undersigned State's non-Medicaid programs approved by CMS in the Medicaid state plan(s) by completing the attached Exhibit A1.
- 7. The approximate enrollment in the undersigned State's Medicaid program at the time of execution of this Amendment is ______.
- 8. As of the effective date of this Amendment, the following are all of the Participating States under the Agreement:

| <u>Michigan</u> | Alaska |
|-----------------|-----------|
| Vermont | Nevada |
| vermont | Nevaua |
| New Hampshire | Tennessee |

9. The contact information for each of the Participating States listed above in section 8 and new states shall be as follows:

State of Michigan Department of Community Health

Medical Services Administration

Attn: Dave McLaury 400 S. Pine Street Lansing, MI 48933

State of Vermont Director of Pharmacy

Office of Vermont Health Access

103 South Main Street Waterbury, VT 05671-1201

State of Nevada Division of Health Care Financing and Policy

Nevada Department of Human Resources

Mark Willden, Director 1100 East Williams Street Carson City, Nevada 89701

State of New Hampshire

State of New Hampshire Department of Health

and Human Services

Commissioner John Stephen

129 Pleasant Street Concord, NH 03301

Dwayne Peeples State of Alaska Director of Health Care Services

State of Alaska Health & Social Services Department

Health Care Services Division 4501 Business Park Boulevard, Ste. 24

Anchorage, AK 99503

State of Tennessee [Name to come]

Bureau of TennCare
Tennessee Department of Finance and Administration

729 Church Street Nashville, TN 37247-6501

| STATE OF <u>Tennessee</u> , | FIRST HEALTH SERVICES CORF |
|--|----------------------------|
| DEPARTMENT OF Finance & Administration | |
| By: <u>State</u> | Ву: |
| Name: | Name |
| Title: | Title: |
| Date: | Date: |

D1014120

EXHIBIT A1

Participating State's Non-Medicaid Programs Approved by CMS in the Medicaid State Plan(s)

| Participating State: Tennessee | | | |
|---|------------|----------------|-----------|
| Non-Medicaid programs approved by CMS in the Medicaid State | Plan(s)- D | ate of Approva | <u>.l</u> |
| 1. <u>None</u> | _ | | _ |
| 2 | | | |
| 3 | _ | | |
| 4 | _ | | |
| 5 | _ | | |
| 6 | _ | | |
| | | | |

D1024120

Amendment to the Supplemental Drug-Rebate Agreement Between The State of Michigan, First Health Services Corporation And

[Insert Manufacturer Name]

WHEREAS, the State of Michigan, First Health Services Corporation ("First Health"), and (Manufacturer") have entered into a Supplemental Drug-Rebate Agreement Contract # [Insert Contract Number] (the "Agreement"), effective as of [Insert date]; and

WHEREAS, the States of Vermont, Nevada, Alaska, and New Hampshire have become parties to the **Michigan Multi-State Pooling Supplemental Rebate Agreement** by executing the Addendum provided for in Section 9.9 of the Agreement; and

WHEREAS, the states of Hawaii and Tennessee have evidenced an intent to become parties to the Agreement; and

WHEREAS, the Centers for Medicare and Medicaid Services ("CMS") is now requiring certain changes to the Agreement before it will authorize them; and

WHEREAS, additional states have indicated their willingness to become Participating States, as defined in Section 3.14 of the Agreement, and thereby participate in the State Supplemental Rebates (as defined in Section 3.19 of the Agreement) available under the Agreement.

NOW, THEREFORE, IN CONSIDERATION OF THE MUTUAL CONVENANTS, PROMISES AND CONDITIONS CONTAINED HEREIN, THE PARTIES AGREE TO THE FOLLOWING AMENDMENTS TO THE AGREEMENT.

- 1. Section 1.1: The states of Vermont, Nevada, Alaska, and New Hampshire are added on the second line and "State" is changed to "States."
- 2. Any and all references to "U.S. Territories" is stricken from the entire Agreement.
- 3. Section 2.1: On line 3 "State" is changed to "States" and the clauses beginning immediately thereafter with "and/or" are deleted down to "Participating States" on line 8. On the third line, the words "CMS approved state-funded programs" are replaced with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
- 4. Section 3.3 is deleted in its entirety and "Client State(s)" is stricken from the entire agreement.
- 5. Section 3.11: "State" within the parentheses on line one is made "States." In line three, "HHS approved state-funded programs" is deleted and replaced with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)."
- 6. Section 3.12: This section is deleted in its entirety. "First Health Client's States" and "FH Client's States" are stricken from this Agreement.
- 7. Section 3.14: This section is modified to read as follows:

"Participating State(s)" means the (i) States as named in Section 1.1 hereof, and (ii) other states that, subsequent to the execution of this Agreement by the States, elect to participate under this Agreement and have all necessary authorizations and approvals from CMS to do so. Unless otherwise approved by CMS on a state-by-state basis. Participating States shall be limited to ones that have a CMS approved contract under which First Health has been engaged to provide PBA Services to that state. For each new Participating State, a unilateral amendment ("New Participating State Amendment") to this Agreement shall be executed by the new Participating State and First Health and sent to the Manufacturer prior to the Participation Commencement Date. Each Participating State, including the new Participating State, must submit a state plan amendment adding the new Participating State to the Agreement to CMS for approval. A copy of the form Amendment is attached hereto as Exhibit A."

8. Section 3.16: This section is modified to read as follows:

"Participation Commencement Date" means the latter of the date (i) a Manufacturer's Supplemental Covered Product is effectively placed in a Participating States Preferred Drug List Program by distribution of it (via website or otherwise) to providers and prescribers, or (ii) the New Participating State Amendment is received by the Manufacturer from a new Participating State. It is the date when the Participating States entitlement to a rebate from the Manufacturer begins to accrue."

- 9. Section 3.20: On the second line: the phrase "state funded, HHS approved program" is deleted and replaced with "non-Medicaid programs approved by CMS in the state plan(s) as provided in Section 2.1 hereof".
- 10. Section 5.1: The last sentence of this section is modified to read:

"Each Participating State will notify Manufacturer and First Health, within ten (10) business days of adoption and publication of anew or revised Preferred Drug List, when Manufacturer's Supplemental Covered Product is added to the Participating State's Preferred Drug List by providing Manufacturer and First Health a copy of the Preferred Drug List in accordance with the notice provisions of Section 9.2 hereof."

11. Section 8.3 is modified by deleting items (ii) and (iii) so that it now reads as follows:

"Termination by a FH Client of its PBA Services Agreement with First Health shall, as of the same termination effective date, terminate this Agreement as to that Participating State."

12. Section 9.2: This section is modified by adding the notice addresses for Nevada, Vermont, New Hampshire, and Alaska, which are as follows:

Director of Pharmacy Office of Vermont Health Access 103 South Main Street Waterbury, VT 05671-1201 Division of Health Care Financing and Policy Nevada Department of Human Resources Mark Willden, Director 1100 East Williams Street Carson City, Nevada 89701

State of New Hampshire Department of Health and Human Services Commissioner John Stephen 120 Pleasant Street Concord, NH 03301

Dwayne Peeples
Director of Health Care Services
State of Alaska Health & Social Services Department
Health Care Services Division
4501 Business Park Boulevard, Ste. 24
Anchorage, AK 99503

13. Section 9.9: This section is modified to read as follows:

"This Agreement will not be altered except by (1) an amendment in writing signed by all the parties, other than (ii) in the case of the addition of a new Participating State(s), by its execution of the New Participating State Amendment, both (i) and (ii) of which shall require the approval of CMS. It is acknowledged that the intent of the previous sentence is that the addition of new Participating State(s) by amendment shall only require the consent of First Health and the approval of CMS, not Manufacturer. Manufacturer agrees that any Participating State may be added to this Agreement by amendment and that said Participating State's covered Medicaid (and other non-Medicaid programs approved by CMS in the Medicaid state plan(s)) lives shall apply to the provision of Schedules 2 and 3 and will affect the rebates to all Participating States in accordance with Schedules 2 and 3. The New Participating State Amendment shall be executed by First Health and the new Participating State with a copy provided to Manufacturer for its records. Other than as stated herein, no individual is authorized to alter or vary the terms or make any representation or inducement relative to it, unless the alteration appears by way of a written amendment, signed by duly appointed representatives of the Participating State(s), First Health, and the Manufacturer."

- 14. Section 9.11: In the second line, replace "other state funded" with "non-Medicaid programs approved by CMS in the Medicaid state plan(s)".
- 15. Except as expressly amended herein, all other terms, conditions and provisions of the Agreement shall remain in full force and effect and the parties hereto hereby ratify and confirm the same as of the date hereof. To the extent that any provisions of this Amendment conflict with the provisions of the Agreement, the provisions of Amendment shall control.

As evidence of their agreement to the foregoing terms and conditions, the parties have signed below:

MANUFACTURER Date: By:___ Name:____ Title: FIRST HEALTH SERVICES CORPORATION Name: Teresa R. DiMarco Title: President STATE OF MICHIGAN, DEPARTMENT OF COMMUNITY HEALTH Name: Title: STATE OF VERMONT, DEPT. OF PREVENTION, ASSISTANCE, TRANSITION AND ACCESS STATE OF NEVADA, DEPARTMENT OF HEALTH CARE FINANCING AND POLICY STATE OF ALASKA, DIVISION OF HEALTH CARE SERVICES Name: STATE OF NEW HAMPSHIRE DEPARTMENT OF HEALTH & HUMAN SERVICES Date: